

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5729

CERTIFICATE OF DEATH

Reg. Dist. No.

05704

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Palmer Middle Eddy Last Allen				4. DATE OF DEATH Month May Day 5 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4.1.88	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 5 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Policeman	
11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Palmer A. Allen				14. MOTHER'S MAIDEN NAME Callie Summers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital Records,				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm Aorta DUE TO (c) Atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 days 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/30 , 19 59 , to 5/5 , 19 59 , that I last saw the deceased alive on 5/4/59 , 19 59 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird, M. D.				ADDRESS (Street, city or town, state) Sandy Spring, Md.			
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.				DATE SIGNED 5.5.59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF May 7-59		22c. NAME OF CEMETERY OR CREMATORY Edgar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Saintland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Sammons Brothers				ADDRESS 1661-94 Hope		24a. REC'D BY REGISTRAR DATE MAY 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death 1918		Place of Death Baltimore, Md.	
Name of Deceased John Doe		Sex Male	
Age 45		Race White	
Date of Birth 1873		Place of Birth Baltimore, Md.	
Cause of Death Heart Disease		Manner of Death Natural	
Signature of Physician J. A. Smith		Signature of Registrar W. B. Jones	
Date of Signature 1918		Place of Signature Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18, Parts MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

I & II

7/6/59 RS Film # C 244

CERTIFICATE OF DEATH

05705

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 3636 16th St., N.W. - Apt. B633		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Albert Herman ARONSON		4. DATE OF DEATH Month May Day 12 Year 19 59		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-1-66		9. AGE (In years last birthday) yrs. 93		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (D) Miss Alice H. Aronson, same as #2 above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, Acute, generalized 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma, ascending colon with perforation DUE TO (c) Myocardial infarction; Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 5 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Denver		(County) (State)	
21. I certify that I attended the deceased from May 10 , 19 59 , to May 12 , 19 59 , that I last saw the deceased alive on May 11 , 19 59 , and that death occurred at 12:50A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE M. C. Shea		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC		DATE SIGNED 5-12-59					
PHYSICIAN'S NAME (Type) M. C. SHEA, Lieutenant, MC, USN Bethesda, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 5-13-59		22c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery		22d. LOCATION (City, town, or county) Denver		(State) Colorado	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Fumolee		ADDRESS Fumolee Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass			

00381

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

323 144

REG. NO.

State of Maryland

County

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Married

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Residence ()

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5731 CERTIFICATE OF DEATH

Reg. Dist. No. 05706

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2600 ELMONT ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>WHEATON-</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE ESTELLE AUBINOE</u>				4. DATE OF DEATH Month Day Year <u>MAY 21 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/3/90</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM. E. RANDALL</u>				14. MOTHER'S MAIDEN NAME <u>MAY DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Mr. Harry S. Aubinoe, 2600 Elmont St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden Occlusion of the Heart des. Coronary</u> DUE TO (c) <u>at circumflex</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 19, 1959</u> to <u>May 21, 1959</u> , that I last saw the deceased alive on <u>May 21, 1959</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George A. Grauer</u> M.D.				ADDRESS (Street, city or town, state) <u>104 Cherry Chase Rd. S 21/59</u>			
PHYSICIAN'S NAME (Type) <u>George A. GRAUER</u>				DATE SIGNED <u>May 21/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5710 CERTIFICATE OF DEATH

Reg. Dist. No.

05707

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		1. d. STREET ADDRESS 12,022 BLUHILL ROAD	
3. NAME OF DECEASED (Type or print) First Arthur Middle ANDREW Last Austin		4. DATE OF DEATH Month May Day 25 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/24
9. AGE (In years, last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER OF MARKET		10b. KIND OF BUSINESS OR INDUSTRY MARKET	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES R. AUSTIN		14. MOTHER'S MAIDEN NAME CINNIE WAGES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 243-24-7194	
17. INFORMANT Mrs. Ramona H. Austin, 12,022 Bluhill Road, Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) Acute Pancreatitis DUE TO (c) 7 days		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 58 , to 5/24 , 19 59 , that I last saw the deceased alive on 5/24/59 , 19 59 , and that death occurred at 8:10 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles M. Weber		ADDRESS (Street, city or town, state) DATE SIGNED 12600 PARKLAWN DRIVE ROCKVILLE MD	
PHYSICIAN'S NAME (Type) CHARLES M. WEBER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/27/59	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zick		24a. REC'D BY REGISTRAR DATE MAY 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Coroner Notified (Dr. Ball)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
5732 CERTIFICATE OF DEATH									
Reg. Dist. No. 05708									
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M ARLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA					c. LENGTH OF STAY IN 1b 45 mins.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital					1 d. STREET ADDRESS 1701 Crawford Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ivy (Iris) L. Bauer					4. DATE OF DEATH Month May Day 7 Year 19 9				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29, 1905		9. AGE (In years lost birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY Foxhall Beauty Shop Balto. Md.		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George E. Wayson					14. MOTHER'S MAIDEN NAME Mary L. Hudson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 578 03 1040				
					INFORMANT Address Mrs. Richard Bentz, 2814 Cheswold Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 3 1/4 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3/5 , 19 59 to 3/7 , 19 59 , that I last saw the deceased alive on 5/7 , 19 59 , and that death occurred at 11:15/17 , M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Allen J. O'Neill M.D.					ADDRESS (Street, city or town, state) 8601 old Georgetown Rd Bethesda Md.				
PHYSICIAN'S NAME (Type) Allen J. O'Neill									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF May 12/59		22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors ADDRESS 4101 E. ndson Ave.					24a. REC'D BY REGISTRAR DATE MAY 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

STATE OF NEW YORK
CERTIFICATE OF DEATH

3733

10376

Decedent's Name: *John J. Smith*
Age: *45*
Sex: *Male*
Race: *White*
Date of Birth: *Jan. 15, 1900*
Place of Birth: *New York City*
Usual Residence: *123 Main St., New York City*
Cause of Death: *Heart Disease*
Date of Death: *Jan. 20, 1945*
Place of Death: *Home*
Physician: *Dr. J. H. Jones*
Manner of Death: *Natural*
Burial Place: *St. John's Cemetery, New York City*

John J. Smith
Jan. 20, 1945
St. John's Cemetery, New York City
Dr. J. H. Jones
123 Main St., New York City
Heart Disease
Natural
St. John's Cemetery, New York City

5733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05709

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Germany</u> b. COUNTY <u>Weilheim</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>19 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12921 Maty Rd</u>		e. STREET ADDRESS <u>8 Markt Platz</u>	
3. NAME OF DECEASED (Type or print) <u>Eugen Wilhelm Banerle</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>X</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist (Dental Surgeon)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u> ✓	
13. FATHER'S NAME <u>Wilhelm Banerle</u>		14. MOTHER'S MAIDEN NAME <u>MARIA BAUR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rebma A. Barker - daughter - Item 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>5-23-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>TRANS. & BURIAL</u>	<u>5/25/59</u>	<u>GERMAN WAR VETERANS CEMETERY</u>	<u>CHICAGO, ILLINOIS</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Zuka</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

FOR STATE
HEALTH DEPT.

5733

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5734 CERTIFICATE OF DEATH

Reg. Dist. No.

05710

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlantic Beach</u> 48X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>P.O. Box 1782</u>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Page</u> Last <u>Borden</u>			4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1911</u>		9. AGE (In years last birthday) <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>John C. Borden</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>Unascertainable</u>		
17. INFORMANT <u>The Medical Record</u>			Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease with mitral stenosis and mitral insufficiency</u> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe emphysema</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 3, 1959</u> to <u>May 25, 1959</u> , that I last saw the deceased alive on <u>May 25, 1959</u> , and that death occurred at <u>10:02 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>5-25-59</u> ACTUAL SIGNATURE <u>William P. Cornell</u> M.D. <u>National Institutes of Health</u> NAME (Type) <u>William P. Cornell, M.D.</u> <u>Bethesda 14, Maryland</u>					
22a. BURIAL, CREMATION, or other disposal <u>Trans Burial</u>		22b. DATE THEREOF <u>5/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Jacksonville Florida</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Pumphrey</u>			24a. RECEIVED BY REGISTRAR <u>MAY 28 1959</u>		
24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>					

STATE CERTIFICATE OF DEATH

15710

WILLIAM BOND

NAME OF DECEASED		WILLIAM BOND	
AGE		65	
SEX		Male	
RACE		White	
DATE OF DEATH		March 15, 1955	
PLACE OF DEATH		Home	
CAUSE OF DEATH		Heart Disease	
MANNER OF DEATH		Natural	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF CORONER		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
DATE OF ENTRY		March 15, 1955	
PLACE OF ENTRY		Baltimore, Maryland	
OFFICIAL USE		[Blank]	
FEE		[Blank]	
REMARKS		[Blank]	
SIGNATURE OF REGISTRAR		[Signature]	
DATE OF REGISTRATION		March 15, 1955	
PLACE OF REGISTRATION		Baltimore, Maryland	
OFFICIAL USE		[Blank]	
FEE		[Blank]	
REMARKS		[Blank]	



15710

15710

15710

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5711

CERTIFICATE OF DEATH

Reg. Dist. No.

05711

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 Akoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>				1615.2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington State Hospital</u>				d. STREET ADDRESS <u>6616 24th ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Victoria</u> Middle <u>Elizabeth</u> Last <u>Boschet</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-9-15</u>	
9. AGE (In years, last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk typist</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joseph Mac Galliard</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Cone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post Hemorrhagic hyaline coma</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis of the liver</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>approx 10 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/30</u> , 19 <u>59</u> , to <u>5/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/2</u> , 19 <u>59</u> , and that death occurred at <u>5:25 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6826 Piggott, Hyattsville, Md</u> DATE SIGNED <u>5/3/59</u> ACTUAL SIGNATURE <u>Wayne Glickfield</u> M.D. PHYSICIAN'S NAME (Type) <u>H. WAYNE GLICKFIELD, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Portsmouth, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Hume Co. 2901-14</u>				ADDRESS <u>625 N. 1st St.</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5735

CERTIFICATE OF DEATH

05712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Drury</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery Co. Gen. Hspil</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Clara Jane Bowman</i>		4. DATE OF DEATH <i>May - 2 - 1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec-12-1879</i>
9. AGE (In years, last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>4</i> Days <i>28</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic nursing</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>nursing</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Columbus Crawford</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Della Ray</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Eleama King R-2-Boyd, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X Acute coronary - congestive failure</i> DUE TO <i>Diabetes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO <i></i> (c) <i></i> INTERVAL BETWEEN ONSET AND DEATH <i>few hours 5-10 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April - 14 - 1959</i> to <i>May - 2 - 1959</i> , that I last saw the deceased alive on <i>May - 1 - 1959</i> , and that death occurred at <i>8:20 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller</i> M.D.		ADDRESS (Street, city or town, state) <i>7-Brooks Ave, Grithersburg, Md</i>	
DATE SIGNED <i>May - 1 - 1959</i>			
PHYSICIAN'S NAME (Type) <i>William C. Miller</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-5-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Upper Seneca Baptist Ch</i>	22d. LOCATION (City, town, or county) (State) <i>Cedar Grove Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bruce E. Hartman</i>		ADDRESS <i>Grithersburg, Md</i>	
24a. REC'D BY REGISTRAR <i>May 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

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William C. Miller
William F. Miller
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Apr - 14 - ad

5736

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 hrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS Rt. #3, Box 338 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby "Randolph" N. BOWMAN		4. DATE OF DEATH Month May Day 1 Year 19 59	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-59
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2	IF UNDER 24 HRS Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. BOWMAN		14. MOTHER'S MAIDEN NAME Jeanette V. BLOMQUIST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH immed. 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1 , 19 59 , to May 1 , 19 59 , that I last saw the deceased alive on May 1 , 19 59 , and that death occurred at 5:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 5-2-59			
ACTUAL SIGNATURE David Harris M.D.		DATE SIGNED 5-2-59	
PHYSICIAN'S NAME (Type) David HARRIS, LT, MC, USN		ADDRESS Bethesda 14, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-4-59	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	22d. LOCATION (City, town, or county) (State) Glen Burnie Md.
23. FUNERAL DIRECTOR'S SIGNATURE Richard L. Singleton		24a. REC'D BY REGISTRAR DATE MAY 6 '59	
ADDRESS Singleton Funeral Home, Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

2051317XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF TOWN CLERK		23. SIGNATURE OF TOWN ENGINEER		24. SIGNATURE OF TOWN CHURCH	
25. SIGNATURE OF TOWN SCHOOL		26. SIGNATURE OF TOWN CHURCH		27. SIGNATURE OF TOWN SCHOOL	
28. SIGNATURE OF TOWN CHURCH		29. SIGNATURE OF TOWN SCHOOL		30. SIGNATURE OF TOWN CHURCH	
31. SIGNATURE OF TOWN SCHOOL		32. SIGNATURE OF TOWN CHURCH		33. SIGNATURE OF TOWN SCHOOL	
34. SIGNATURE OF TOWN CHURCH		35. SIGNATURE OF TOWN SCHOOL		36. SIGNATURE OF TOWN CHURCH	
37. SIGNATURE OF TOWN SCHOOL		38. SIGNATURE OF TOWN CHURCH		39. SIGNATURE OF TOWN SCHOOL	
40. SIGNATURE OF TOWN CHURCH		41. SIGNATURE OF TOWN SCHOOL		42. SIGNATURE OF TOWN CHURCH	
43. SIGNATURE OF TOWN SCHOOL		44. SIGNATURE OF TOWN CHURCH		45. SIGNATURE OF TOWN SCHOOL	
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49. SIGNATURE OF TOWN SCHOOL		50. SIGNATURE OF TOWN CHURCH		51. SIGNATURE OF TOWN SCHOOL	
52. SIGNATURE OF TOWN CHURCH		53. SIGNATURE OF TOWN SCHOOL		54. SIGNATURE OF TOWN CHURCH	
55. SIGNATURE OF TOWN SCHOOL		56. SIGNATURE OF TOWN CHURCH		57. SIGNATURE OF TOWN SCHOOL	
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67. SIGNATURE OF TOWN SCHOOL		68. SIGNATURE OF TOWN CHURCH		69. SIGNATURE OF TOWN SCHOOL	
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97. SIGNATURE OF TOWN SCHOOL		98. SIGNATURE OF TOWN CHURCH		99. SIGNATURE OF TOWN SCHOOL	
100. SIGNATURE OF TOWN CHURCH		101. SIGNATURE OF TOWN SCHOOL		102. SIGNATURE OF TOWN CHURCH	

1

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BACILLI ONE 18

5737 CERTIFICATE OF DEATH

05714

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 59 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 7220 Everglades Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Emma Elizabeth BRADFORD				4. DATE OF DEATH Month Day Year May 11 1959			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-05	
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Radcliff				14. MOTHER'S MAIDEN NAME Elizabeth Stevenson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Squamous cell carcinoma, uterus DUE TO (c) Adenocarcinoma, colon						INTERVAL BETWEEN ONSET AND DEATH 4 mos 3 yrs 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 13 , 19 59 , to May 11 , 19 59 , that I last saw the deceased alive on May 11 , 19 59 , and that death occurred at 3:00P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. M. Garland, Jr.				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 5-12-59			
PHYSICIAN'S NAME (Type) C. M. GARLAND, JR., CDR, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers, 1400 Chapin St., N.W., Wash. DC				24a. REC'D BY REGISTRAR DATE MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DOI: 10.1002/for

5738

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8505 Lynnbrook Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle M. Last BROADHURST		4. DATE OF DEATH Month May Day 8 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/1892
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months 5 Days 4	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helen's Doll Shop--Owner		10b. KIND OF BUSINESS OR INDUSTRY Maryland	11. BIRTHPLACE (State or foreign country) USA
13. FATHER'S NAME George A. Broadhurst		14. MOTHER'S MAIDEN NAME Valie Dixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-26-4114	
INFORMANT Helen Broadhurst-wife-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolization 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease, Mitral Stenosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH Instant 54 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7 , 19 47 , to May 8 , 19 59 that I last saw the deceased alive on May 8 , 19 59 , and that death occurred at 9:55P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Angle		ADDRESS (Street, city or town, state) DATE SIGNED 5009 Del Ray Ave., Bethesda, Md 5/9/59	
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.		5009 Del Ray Ave., Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-11-59	22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery.	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR MAY 12 '59	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05215

CENTRAL STATE OF DEATH

2730

Montgomery

Maryland

Alabama

Delaware

800 Westwood Drive

800 Westwood Drive

Age

Age

White

White

Robert A. Bell

Robert A. Bell

George A. Robinson

George A. Robinson

877-10-1111

Instant

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Respiratory Arrest

Respiratory Arrest

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Robert A. Bell

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Robert A. Bell

CERTIFICATE OF DEATH

Reg. Dist. No.

05716

5739

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Rd.		d. STREET ADDRESS Brooke Road	
3. NAME OF DECEASED (Type or print) First Susan Middle Denise Last Brooks		4. DATE OF DEATH Month May Day 15 Year 19 59	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allen Warfield Brooks		14. MOTHER'S MAIDEN NAME Robinette Viola Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record, Montgomery Co. Gen. Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration of stomach contents DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vomited and strangled			
20c. TIME OF INJURY Month, Day, Year Hour 6:05 p. m. 5 15 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) own home		20f. (City or town) Brooke Rd. Sandy Spr. Montg. Md. (County) (State)	
21. I certify that I attended the deceased from 4/28 , 19 59 , to 5/15 , 19 59 , that I last saw the deceased alive on 5/15 , 19 59 , and that death occurred at 5:30PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. Ligon		ADDRESS (Street, city or town, state) Sandy Spring, Md. DATE SIGNED 5/17/59	
PHYSICIAN'S NAME (Type) C. H. Ligon			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/16/59	22c. NAME OF CEMETERY OR CREMATORY Sandy Spring	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Lunden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR MAY 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073278XV2

CERTIFICATE OF DEATH

MAJOR AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

2522

Richard [illegible]

NAME

1976

Book 2

BOOK

DATE

1976

DECEASED

AGE

SEX

RACE

CAUSE

MANNER

PLACE

TIME

SIGNATURE

DATE

Richard [illegible]

1976

Richard [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG242 5-11-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05717

5740

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 9810 Georgia Avenue d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Matile Lane Sanatorium		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY New York Brooklyn c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Brooklyn d. STREET ADDRESS 4401 Clarendon Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALVINA Middle G. Last BROWN		4. DATE OF DEATH Month MAY Day 2 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 2 Hours 19 Min.	IF UNDER 24 HRS. Months 7 Days 2 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Connecticut	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Merrath Bleichner		14. MOTHER'S MAIDEN NAME Celine Oberhaseur	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Benj. Newton		Address 4700 Broad Brook Drive Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ESSENTIAL HYPERTENSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 24, 1958 , to MAY 2, 1959 , that I last saw the deceased alive on MAY 2, 1959 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5206 NORMAN AVE. 5/2/59 DATE SIGNED ACTUAL SIGNATURE Henry M. Lowden M.D. PHYSICIAN'S NAME (Type) Henry M. Lowden Chen Chong, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 4/5/59	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Bronx, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR MAY 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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5741

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3920 Baltimore Street				d. STREET ADDRESS 3920 Baltimore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle W Last BROWN				4. DATE OF DEATH Month May Day 25 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/31/1875	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 4 Days 27		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Frederick T. Brown				14. MOTHER'S MAIDEN NAME Annie Bates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. INFORMANT Address Yes-Unknown Fannie I Brown-wife-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Coronary atherosclerosis (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/20, 1959 , to 5/25, 1959 , that I last saw the deceased alive on 5/22, 1959 , and that death occurred at 2:00 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Ga. Ave. Silver Spring DATE SIGNED 							
ACTUAL SIGNATURE Donald Nelson M.D.							
PHYSICIAN'S NAME (Type) Donald Nelson Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/27/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAY 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

03718

CERTIFICATE OF DEATH

2741

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
OFFICIAL: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5742

CERTIFICATE OF DEATH

Reg. Dist. No.

05719

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>D.O.A.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jesse</i> Middle <i>A.</i> Last <i>Brown</i>		4. DATE OF DEATH Month <i>5</i> Day <i>26</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 17, 1890</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>6</i> Days <i>9</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Guthrie's Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Irving A. Brown</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ann Cunningham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-09-1984</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute Coronary Thrombosis -</i> DUE TO (c) <i>Coronary Atherosclerotic Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>1 month.</i>		18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma Prostate & pelvic & spine metastases.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October 58</i> to <i>May 26</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>May 14</i> , 19 <i>59</i> , and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Blaine Fitzgerald</i>		ADDRESS (Street, city or town, state) <i>8218 Wisconsin Avenue Bethesda, Maryland.</i>	
PHYSICIAN'S NAME (Type) <i>J. Blaine Fitzgerald</i>		DATE SIGNED <i>5/26/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/29/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR <i>MAY 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hwang</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5743

05720

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN lb <u>10 yrs</u>		d. STREET ADDRESS <u>2710 Arcola Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2710 Arcola Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frederick Slater Butler Jr.</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1927</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manitance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gas co.</u>	
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Frederick S. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Irma Bastin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> WW # <u>2</u>		16. SOCIAL SECURITY NO. <u>578-30-6964</u>	
17. INFORMANT <u>Letitia Butler (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 974x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hanging</u> (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found hanging by neck in basement of his home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 30 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>SILVER SPRING, MD.</u> DATE <u>JUN 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5744 CERTIFICATE OF DEATH

05721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 43 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 ROCKVILLE d. STREET ADDRESS 914 GRANDIN AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle MAYNARD Last CAREY		4. DATE OF DEATH Month MAY Day 23 Year 19 59					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/94	9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months 9 Days 27		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER		10b. KIND OF BUSINESS OR INDUSTRY GRAND UNION MARKET		11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME JOHN RICHARD CAREY			14. MOTHER'S MAIDEN NAME MARY CATHERINE DEAN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED METASTASIS DUE TO (c) CARCINOMA OF COLON					INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 6 MONTHS 7 MONTHS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from February, 19 59 , to 23 May, 19 59 , that I last saw the deceased alive on MAY 23 19 59 , and that death occurred at 2:50 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Gordon S. Rosenberger M.D. 23 May 19 59							
ACTUAL SIGNATURE Gordon S. Rosenberger		PHYSICIAN'S NAME (Type) GORDON S. ROSENBERGER, M. D. GAITHERSBURG, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-26-59	22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland			24a. REC'D BY REGISTRAR MAY 27 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

65751

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

DEPARTMENT

MARYLAND

REGISTER

DATE OF DEATH

1914

TIME

PLACE OF DEATH

HOME

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

PROFESSION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME

SEX

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5745 CERTIFICATE OF DEATH

05722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 1 - Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg Maryland</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>none</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Frederick CARL</u>		4. DATE OF DEATH Month Day Year <u>MAY 12 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1929</u> 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dairyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>
13. FATHER'S NAME <u>Edmund O. Carl</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Beuchert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-14-4042</u>	17. INFORMANT Address <u>Mrs. Sarah F. Carl Route 1 - Gaithersburg</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction?</u> <u>584X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Biliary Lithiasis?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 MIN</u> <u>3 MIN</u> <u>6 Mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden Death - await autopsy report</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 8</u> , 19 <u>56</u> , to <u>12 MAY</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12 MAY</u> , 19 <u>59</u> , and that death occurred at <u>3:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Boschen Ziegler</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12 MAY 59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSCHEN ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>13705 - Gaithersburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Adams Funeral Home 4746 - Wisconsin Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 15 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

45782

REG. NO. 100

<p>1. PLACE OF DEATH</p> <p>Home</p>		<p>2. COUNTY</p> <p>Harford</p>	
<p>3. DATE OF DEATH</p> <p>May 10, 1967</p>		<p>4. TIME OF DEATH</p> <p>10:00 AM</p>	
<p>5. NAME OF DECEASED</p> <p>Robert L. ...</p>		<p>6. SEX</p> <p>Male</p>	
<p>7. AGE</p> <p>68</p>		<p>8. RACE</p> <p>White</p>	
<p>9. OCCUPATION</p> <p>Retired</p>		<p>10. MARITAL STATUS</p> <p>Married</p>	
<p>11. PLACE OF BIRTH</p> <p>Harford, Maryland</p>		<p>12. DATE OF BIRTH</p> <p>May 10, 1900</p>	
<p>13. NAME OF PHYSICIAN</p> <p>Dr. ...</p>		<p>14. NAME OF HOSPITAL</p> <p>...</p>	
<p>15. NAME OF FUNERAL HOME</p> <p>...</p>		<p>16. NAME OF MINISTER</p> <p>...</p>	
<p>17. NAME OF NEXT OF KIN</p> <p>...</p>		<p>18. NAME OF WITNESS</p> <p>...</p>	
<p>19. SIGNATURE OF REGISTRAR</p> <p>...</p>		<p>20. SIGNATURE OF DECEASED</p> <p>...</p>	

45782



1967 MAY 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5746

CERTIFICATE OF DEATH

Reg. Dist. No.

05723

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson		c. LENGTH OF STAY IN 1b 70 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson	
		d. STREET ADDRESS Rural	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Maurice Carlisle, Sr.		4. DATE OF DEATH Month Day Year 5 19 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 4, 1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm & Dairy	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard C. Carlisle		14. MOTHER'S MAIDEN NAME Frances Appleby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-38-3162	
17. INFORMANT Betty C. Carlisle		Address Dickerson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 15 minutes 2 year 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Nov , 19 54 , to 19 May , 19 59 , that I last saw the deceased alive on 19 May , 19 59 , and that death occurred at 10:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		ADDRESS (Street, city or town, state) Barnesville, Md.	
PHYSICIAN'S NAME (Type) Gordon M. Smith		DATE SIGNED 21 May 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/59	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR Barnesville Md.	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume		DATE MAY 25 '59	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5747

CERTIFICATE OF DEATH

05724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Adena c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 72 x -3 d. STREET ADDRESS Rural Delivery 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Carpenter		4. DATE OF DEATH Month May Day 23 Year 1959					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1947	9. AGE (In years last birthday) 11 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio			
13. FATHER'S NAME Andrew Carpenter		14. MOTHER'S MAIDEN NAME Nettie Williams					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Congestive Heart Failure following complete repair of Tetralogy of Fallot. DUE TO Severe Polycythemia secondary to Tetralogy of Fallot. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subacute Bacterial Endocarditis. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					INTERVAL BETWEEN ONSET AND DEATH		
21. I certify that I attended the deceased from May 12 , 19 59 , to May 23 , 19 59 , that I last saw the deceased alive on May 23 , 19 59 , and that death occurred at 3:00 A M, from the causes and on the date stated above. ACTUAL SIGNATURE William P. Cornell M.D. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/23/59 PHYSICIAN'S NAME (Type) WILLIAM P. CORNELL, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, OR DISPOSITION (Specify) Burial		22b. DATE THEREOF 5/26/59		22c. NAME OF CEMETERY OR CREMATORY New Alexandria Cem.			
23. REGISTRAR'S SIGNATURE Robert A. Pumphrey, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

103734

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Robert A. Thompson, Baltimore, Md.

5/25/33

54 years old

White

Male

Single

Occupation

Residence

Place of birth

Duration of residence in Maryland

Cause of death

Immediate cause of death

Underlying cause of death

Contributing causes of death

Place of death

Time of death

Signature of physician

Signature of registrar

Signature of informant

Signature of witness

Signature of funeral director

Signature of undertaker

Signature of cemetery

Signature of burial place

Signature of interment

Signature of burial

Signature of burial

Signature of burial

Signature of burial

Signature of burial

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1
FOR STATE
HEALTH DEPT.

5748

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05725

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Monrovia		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS RFD Monrovia	
3. NAME OF DECEASED (Type or print) First Edna Middle Pearl Last Clay		4. DATE OF DEATH Month May Day 30 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1908
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop.		10b. KIND OF BUSINESS OR INDUSTRY Resturant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward King		14. MOTHER'S MAIDEN NAME Jessie Ridgley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-9974	
17. INFORMANT Wilson E. Clay, Monrovia, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic and cerebral hemorrhage 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet wounds in left chest and base of left skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH few minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was shot by husband	
20c. TIME OF INJURY Month, Day, Year 8:29 PM 5/30/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) RFD, Monrovia, Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY Providence Meth.		22d. LOCATION (City, town, or county) (State) Kempton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Mohrman		24a. REC'D BY REGISTRAR DATE JUN 3 '59	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
RECORDING

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Residence	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Place of Issuance		Official Seal	

5749

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05726

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Monrovia		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Monrovia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Wilson Middle Carroll Last Clay			4. DATE OF DEATH Month May Day 30 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1901	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME Harry Clay		
14. MOTHER'S MAIDEN NAME Ella Rhinehart			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-36-7843			17. INFORMANT Wilson E. Clay, Monrovia, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic and cerebral hemorrhage 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet wounds in left chest and right skull DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Few minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wounds			
20c. TIME OF INJURY Month, Day, Year 8:30 PM 5/30/59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) RFD Monrovia, Montg. Co. Md.	(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/30/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 2, 1959	22c. NAME OF CEMETERY OR CREMATORY Providence Meth.	22d. LOCATION (City, town, or county) (State) Kempton, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Mohr		ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JUN 3 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5750 CERTIFICATE OF DEATH

05727

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAPLE LANE NURSING HOME		d. STREET ADDRESS 644 MASS. AVE., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle ELIZABETH Last COBURN		4. DATE OF DEATH Month MAY Day 8 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/74
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving U.S. Government	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD FREE		14. MOTHER'S MAIDEN NAME ROSELLA GOODWIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Dorothy C. Carmichael		Address 8408 Houston St. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG 14 , 19 56 , to MAY 8 , 19 59 , that I last saw the deceased alive on MAY 8 , 19 59 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Lowden M.D.		ADDRESS (Street, city or town, state) 5206 Norway Dr. DATE SIGNED 5/8/59	
PHYSICIAN'S NAME (Type) HENRY M. LOWDEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/11/59	22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAY 15 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

5751 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 6 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4344 East West Highway				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 4344 East West Highway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mildred A. Cook				4. DATE OF DEATH Month Day Year May 29, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 30, 1868	
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days 3 29		11. IF UNDER 24 HRS. Hours Min. 3 29			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Wathan Marple				14. MOTHER'S MAIDEN NAME Elizabeth Dickinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Dr. E. Russell Cook-Item #2-son	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Pulmonary congestion, acute DUE TO (b) arteriosclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 5 days 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1950 , 19____, to 29 May, 1959 that I last saw the deceased alive on 29 May , 19____, and that death occurred at 4:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7659 Old Georgetown Road Bethesda, Maryland DATE SIGNED 6/1/59							
ACTUAL SIGNATURE John M. Wyman, M. D.				DATE SIGNED 6/1/59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/59		22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cem.		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05788

CENTRICITY DASH

2701

Montgomery

Montgomery

Section

454 Main Highway

454 Main Highway

Alfred

Alfred

May 25

Orange White

May 25, 1900

May 25

Housewife

Housewife

U.S.A.

Machine

Machine

No

No

05788

05788

05788

Robert A. Montgomery, Secretary, Montgomery, Alabama

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5752 CERTIFICATE OF DEATH

05729

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Texas b. COUNTY Kleberg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Kingsville 80 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. STREET ADDRESS 1100 East Lott e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cheryl Ann COOLEY		4. DATE OF DEATH Month Day Year May 12 19 59	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-59
9. AGE (In years lost birthday) yrs. 3		IF UNDER 1 YEAR Months Days Hours Min. 3 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Cooley		14. MOTHER'S MAIDEN NAME Geraldine Pedron	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Block + Shock 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ventricular (c) Congenital Heart Disease Septal Defect + Conduction System			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 25 , 19 59 , to May 12 , 19 59 , that I last saw the deceased alive on May 12 , 19 59 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Mazur		ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNMC 5-13-59	
PHYSICIAN'S NAME (Type) John H. MAZUR, LT, MC, USN		Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		22b. DATE THEREOF 5-14-59	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's of the Assumption		22d. LOCATION (City, town, or county) (State) Kulpmont Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Collins Funeral Home		ADDRESS 3821 14th St., NW, Wash. DC	
24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE TO

DEATH CERTIFICATE

Name of deceased		Date of death	
John A. Smith		April 12, 1958	
Age		Sex	
65		Male	
Race		Color	
White		White	
Place of birth		Date of birth	
Baltimore, Md.		April 12, 1958	
Cause of death		Place of death	
Heart disease		Home	
Signed and sealed this 12th day of April, 1958		At Baltimore, Md.	
Physician		Registrar	
J. B. Smith, M.D.		John A. Smith, Jr.	
Signed and sealed this 12th day of April, 1958		At Baltimore, Md.	
Physician		Registrar	
J. B. Smith, M.D.		John A. Smith, Jr.	

5753

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Arlington 83X-3 d. STREET ADDRESS 3112 S. Hayes Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Michael CORLE				4. DATE OF DEATH Month Day Year May 5 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 2	
13. FATHER'S NAME Joseph S. CORLE				14. MOTHER'S MAIDEN NAME Gloria Loraine REINHART			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia secondary to fetal atelectasis and hyaline disease. 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3 , 19 59 , to May 5 , 19 59 , that I last saw the deceased alive on May 4 , 19 59 , and that death occurred at 3:05A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. L. Walton				ADDRESS (Street, city or town, state) U. S. Naval Hospital		DATE SIGNED 5-5-59	
PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR MAY 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Klaus			

2051346XY4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5754

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 46 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avawam		55X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS (None)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ira Middle (None) Last Cornett				4. DATE OF DEATH Month May Day 18 , Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 1, 1918	
9. AGE (In years last birthday) yrs. 40		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Tonsorial		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Cornett				14. MOTHER'S MAIDEN NAME Polly Hoskins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Vascular Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH months years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2 , 19 59 , to May 18 , 19 59 , that I last saw the deceased alive on May 18 , 19 59 , and that death occurred at 7:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-19-59 ACTUAL SIGNATURE John A. Oates, M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-19th. 59		22c. NAME OF CEMETERY OR CREMATORY Family Cemetery.		22d. LOCATION (City, town, or county) (State) Hazard Ky.	
23. FUNERAL DIRECTOR'S SIGNATURE William Demaine & Son.				ADDRESS Alexandria Va.		24a. REC'D BY REGISTRAR DATE MAY 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

105701

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 35	
4. DATE OF DEATH 1968-10-15		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS Hypertension		14. MEDICATION None		15. PHYSICIAN Dr. J. A. Smith	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESSES None		18. SIGNATURE OF PHYSICIAN None	
19. SIGNATURE OF REGISTRAR None		20. SIGNATURE OF CLERK None		21. SIGNATURE OF JURY None	
22. SIGNATURE OF JURY None		23. SIGNATURE OF JURY None		24. SIGNATURE OF JURY None	
25. SIGNATURE OF JURY None		26. SIGNATURE OF JURY None		27. SIGNATURE OF JURY None	
28. SIGNATURE OF JURY None		29. SIGNATURE OF JURY None		30. SIGNATURE OF JURY None	
31. SIGNATURE OF JURY None		32. SIGNATURE OF JURY None		33. SIGNATURE OF JURY None	
34. SIGNATURE OF JURY None		35. SIGNATURE OF JURY None		36. SIGNATURE OF JURY None	
37. SIGNATURE OF JURY None		38. SIGNATURE OF JURY None		39. SIGNATURE OF JURY None	
40. SIGNATURE OF JURY None		41. SIGNATURE OF JURY None		42. SIGNATURE OF JURY None	
43. SIGNATURE OF JURY None		44. SIGNATURE OF JURY None		45. SIGNATURE OF JURY None	
46. SIGNATURE OF JURY None		47. SIGNATURE OF JURY None		48. SIGNATURE OF JURY None	
49. SIGNATURE OF JURY None		50. SIGNATURE OF JURY None		51. SIGNATURE OF JURY None	
52. SIGNATURE OF JURY None		53. SIGNATURE OF JURY None		54. SIGNATURE OF JURY None	
55. SIGNATURE OF JURY None		56. SIGNATURE OF JURY None		57. SIGNATURE OF JURY None	
58. SIGNATURE OF JURY None		59. SIGNATURE OF JURY None		60. SIGNATURE OF JURY None	
61. SIGNATURE OF JURY None		62. SIGNATURE OF JURY None		63. SIGNATURE OF JURY None	
64. SIGNATURE OF JURY None		65. SIGNATURE OF JURY None		66. SIGNATURE OF JURY None	
67. SIGNATURE OF JURY None		68. SIGNATURE OF JURY None		69. SIGNATURE OF JURY None	
70. SIGNATURE OF JURY None		71. SIGNATURE OF JURY None		72. SIGNATURE OF JURY None	
73. SIGNATURE OF JURY None		74. SIGNATURE OF JURY None		75. SIGNATURE OF JURY None	
76. SIGNATURE OF JURY None		77. SIGNATURE OF JURY None		78. SIGNATURE OF JURY None	
79. SIGNATURE OF JURY None		80. SIGNATURE OF JURY None		81. SIGNATURE OF JURY None	
82. SIGNATURE OF JURY None		83. SIGNATURE OF JURY None		84. SIGNATURE OF JURY None	
85. SIGNATURE OF JURY None		86. SIGNATURE OF JURY None		87. SIGNATURE OF JURY None	
88. SIGNATURE OF JURY None		89. SIGNATURE OF JURY None		90. SIGNATURE OF JURY None	
91. SIGNATURE OF JURY None		92. SIGNATURE OF JURY None		93. SIGNATURE OF JURY None	
94. SIGNATURE OF JURY None		95. SIGNATURE OF JURY None		96. SIGNATURE OF JURY None	
97. SIGNATURE OF JURY None		98. SIGNATURE OF JURY None		99. SIGNATURE OF JURY None	
100. SIGNATURE OF JURY None		101. SIGNATURE OF JURY None		102. SIGNATURE OF JURY None	

WILLIAM BROWN

105701

5755

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lorton 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS RR #1, Box 70		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Howell Gardner CRIM				4. DATE OF DEATH Month Day Year May 11 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-98		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Usher		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William S. Crim				14. MOTHER'S MAIDEN NAME Mary B. Hoffmaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> WWI		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (W) Mrs. Sadie M. Crim, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary fibrosis, etiol. undet. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3 , 19 59 , to May 11 , 19 59 , that I last saw the deceased alive on May 9 , 19 59 , and that death occurred at 5:35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 5-11-59							
ACTUAL SIGNATURE Joseph T. Horgan		M.D. U. S. Naval Hospital					
PHYSICIAN'S NAME (Type) Joseph T. HORGAN, LCDR, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-59		22c. NAME OF CEMETERY OR CREMATORY Popick Cemetery		22d. LOCATION (City, town, or county) (State) Fairfax Co. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Funeral Home				24a. REC'D BY REGISTRAR DATE MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

227

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G243 6-2-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05733

5756

1. PLACE OF DEATH a. COUNTY MONTGOME Y b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDNOR d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BELMONT NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOME Y c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDNOR d. STREET ADDRESS Colesville Road, Rt. # 29 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA R. CRUM		4. DATE OF DEATH Month Day Year MAY 23 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/81
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor - Osteopathic		10b. KIND OF BUSINESS OR INDUSTRY Michigan	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Gates		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT BELMONT NURSING HOME RECORDS		Address EDNOR, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) NEPHRITIS		INTERVAL BETWEEN ONSET AND DEATH 6 DAYS YEARS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DECEMBER 1, 19 58 , to MAY 18, 19 59 , that I last saw the deceased alive on MAY 18, 19 59 , and that death occurred at 10:10 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. BIRD, M. D.		ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND	
DATE SIGNED 5/23/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-transit 5-25-59		Ames City Cemetery Ames, Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

5757 CERTIFICATE OF DEATH

05734

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 11 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 518 E Street, S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude		First Gertrude Middle (none) Last Culver		4. DATE OF DEATH Month May Day 5 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 7, 1886	
9. AGE (In years lost birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Holland	
13. FATHER'S NAME John Poll				14. MOTHER'S MAIDEN NAME Boukye van der Meulen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 583X Necrotizing hepatitis etiology DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) undetermined DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 24 , 19 59 , to May 5 , 19 59 , that I last saw the deceased alive on May 5 , 19 59 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/5/59 ACTUAL SIGNATURE Howard M. Radwin, M.D. PHYSICIAN'S NAME (Type) Howard M. Radwin, M. D. The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) 5-8-59				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
				22d. LOCATION (City, town, or county) (State) Suitland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lee's Sons Co. 300-4th St. N.E.				ADDRESS 300-4th St. N.E.		24a. REC'D BY REGISTRAR MAY 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Name of Deceased		John T. ...	
Sex		Male	
Age		35 years	
Date of Death		September 1, 1905	
Place of Death		The Clinical Center, Baltimore, Md.	
Cause of Death		Typhoid fever	
Disease or Condition		Typhoid fever	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		September 1, 1905	
Place of Registration		Baltimore, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05735

5758 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 161 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carolyn Haller CURREY		4. DATE OF DEATH Month Day Year May 12 19 59	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-73
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Haller		14. MOTHER'S MAIDEN NAME Elizabeth Poter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (SINL) Adm. W. F. Boone, USN, same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 2, 19 50 to May 12, 19 59 , that I last saw the deceased alive on May 12, 19 59 , and that death occurred at 5:24 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. H. O'Connell		ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNMC 5-13-59	
PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Shreveport		22b. DATE THEREOF 5-13-59	
22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Shreveport Louisiana	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

55782

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
COUNTY [REDACTED]		CITY [REDACTED]		STATE [REDACTED]	
DATE OF FILING [REDACTED]		TIME OF FILING [REDACTED]		PLACE OF FILING [REDACTED]	

This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the State Department of Health, Birmingham, Alabama, on the [REDACTED] day of [REDACTED], 19[REDACTED].
 [REDACTED]
 [REDACTED]

5712 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
f. STREET ADDRESS <u>La Salle Road</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>Augusta</u> Last <u>DANT</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb + 13, 1878</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Shoemaker</u>				14. MOTHER'S MAIDEN NAME <u>Margaret L. Emmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. Dorothy B. Granados, 804 Kennebunk Ave. T.P.M.D.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>May 22</u> , 19 <u>59</u> , to <u>May 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>59</u> , and that death occurred at <u>7:00 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dorothy B. Granados</u>				ADDRESS (Street, city or town, state) <u>940-25th St, 7. W. Waco, TX 76798</u>			
DATE SIGNED <u>May 31, 1959</u>				PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 3, 1959</u>		<u>London Park Cemetery</u>		<u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll Park W 20c</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>JOHN J. BROWN</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1910</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1935</i></p>	
<p>9. NAME OF SPOUSE <i>John J. Brown</i></p>		<p>10. DATE OF DEATH <i>1955</i></p>	
<p>11. PLACE OF DEATH <i>Baltimore, Md.</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SURVIVAL <i>Yes</i></p>	
<p>15. SIGNATURE OF DECEASED <i>John J. Brown</i></p>		<p>16. SIGNATURE OF WITNESS <i>John J. Brown</i></p>	
<p>17. SIGNATURE OF PHYSICIAN <i>John J. Brown</i></p>		<p>18. SIGNATURE OF JUDGE <i>John J. Brown</i></p>	
<p>19. SIGNATURE OF CLERK <i>John J. Brown</i></p>		<p>20. SIGNATURE OF NOTARY <i>John J. Brown</i></p>	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. DATE OF MARRIAGE
9. NAME OF SPOUSE
10. DATE OF DEATH
11. PLACE OF DEATH
12. CAUSE OF DEATH
13. MEDICAL HISTORY
14. SURVIVAL
15. SIGNATURE OF DECEASED
16. SIGNATURE OF WITNESS
17. SIGNATURE OF PHYSICIAN
18. SIGNATURE OF JUDGE
19. SIGNATURE OF CLERK
20. SIGNATURE OF NOTARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6243 6-17-59 et

CERTIFICATE OF DEATH

05737

Reg. Dist. No.

5759

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Beau Gardens</u>		d. STREET ADDRESS <u>1879 Wyoming Ave. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henrietta A. Darneille</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10 - 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk (Govt)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt</u>	9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin J. Darneille</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Addison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Nursing</u>		Address <u>Next Home Records - same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>on ship</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Nov. 12, 1959</u> to <u>May 5, 1959</u> , that I last saw the deceased alive on <u>May 4, 1959</u> , and that death occurred at <u>5:58</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. B. Thibodeau</u>		ADDRESS (Street, city or town, state) <u>Box 659 Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>R. B. THIBODEAU</u>		DATE SIGNED <u>May 6 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	22d. LOCATION (City, town, or county) _____ (State) _____ <u>Prince Georges Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>	
ADDRESS <u>-Washington, D.C</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

1925

1925

<p>1. Name of deceased: <i>John A. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15, 1880</i></p>	
<p>5. Place of birth: <i>St. Louis, Mo.</i></p>		<p>6. Date of death: <i>Dec 10, 1925</i></p>	
<p>7. Cause of death: <i>Heart disease</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>John A. Smith</i></p>		<p>10. Signature of registrar: <i>John A. Smith</i></p>	
<p>11. Signature of undertaker: <i>John A. Smith</i></p>		<p>12. Signature of witness: <i>John A. Smith</i></p>	
<p>13. Signature of coroner: <i>John A. Smith</i></p>		<p>14. Signature of jury: <i>John A. Smith</i></p>	
<p>15. Signature of jury: <i>John A. Smith</i></p>		<p>16. Signature of jury: <i>John A. Smith</i></p>	
<p>17. Signature of jury: <i>John A. Smith</i></p>		<p>18. Signature of jury: <i>John A. Smith</i></p>	
<p>19. Signature of jury: <i>John A. Smith</i></p>		<p>20. Signature of jury: <i>John A. Smith</i></p>	
<p>21. Signature of jury: <i>John A. Smith</i></p>		<p>22. Signature of jury: <i>John A. Smith</i></p>	
<p>23. Signature of jury: <i>John A. Smith</i></p>		<p>24. Signature of jury: <i>John A. Smith</i></p>	
<p>25. Signature of jury: <i>John A. Smith</i></p>		<p>26. Signature of jury: <i>John A. Smith</i></p>	
<p>27. Signature of jury: <i>John A. Smith</i></p>		<p>28. Signature of jury: <i>John A. Smith</i></p>	
<p>29. Signature of jury: <i>John A. Smith</i></p>		<p>30. Signature of jury: <i>John A. Smith</i></p>	
<p>31. Signature of jury: <i>John A. Smith</i></p>		<p>32. Signature of jury: <i>John A. Smith</i></p>	
<p>33. Signature of jury: <i>John A. Smith</i></p>		<p>34. Signature of jury: <i>John A. Smith</i></p>	
<p>35. Signature of jury: <i>John A. Smith</i></p>		<p>36. Signature of jury: <i>John A. Smith</i></p>	
<p>37. Signature of jury: <i>John A. Smith</i></p>		<p>38. Signature of jury: <i>John A. Smith</i></p>	
<p>39. Signature of jury: <i>John A. Smith</i></p>		<p>40. Signature of jury: <i>John A. Smith</i></p>	
<p>41. Signature of jury: <i>John A. Smith</i></p>		<p>42. Signature of jury: <i>John A. Smith</i></p>	
<p>43. Signature of jury: <i>John A. Smith</i></p>		<p>44. Signature of jury: <i>John A. Smith</i></p>	
<p>45. Signature of jury: <i>John A. Smith</i></p>		<p>46. Signature of jury: <i>John A. Smith</i></p>	
<p>47. Signature of jury: <i>John A. Smith</i></p>		<p>48. Signature of jury: <i>John A. Smith</i></p>	
<p>49. Signature of jury: <i>John A. Smith</i></p>		<p>50. Signature of jury: <i>John A. Smith</i></p>	
<p>51. Signature of jury: <i>John A. Smith</i></p>		<p>52. Signature of jury: <i>John A. Smith</i></p>	
<p>53. Signature of jury: <i>John A. Smith</i></p>		<p>54. Signature of jury: <i>John A. Smith</i></p>	
<p>55. Signature of jury: <i>John A. Smith</i></p>		<p>56. Signature of jury: <i>John A. Smith</i></p>	
<p>57. Signature of jury: <i>John A. Smith</i></p>		<p>58. Signature of jury: <i>John A. Smith</i></p>	
<p>59. Signature of jury: <i>John A. Smith</i></p>		<p>60. Signature of jury: <i>John A. Smith</i></p>	
<p>61. Signature of jury: <i>John A. Smith</i></p>		<p>62. Signature of jury: <i>John A. Smith</i></p>	
<p>63. Signature of jury: <i>John A. Smith</i></p>		<p>64. Signature of jury: <i>John A. Smith</i></p>	
<p>65. Signature of jury: <i>John A. Smith</i></p>		<p>66. Signature of jury: <i>John A. Smith</i></p>	
<p>67. Signature of jury: <i>John A. Smith</i></p>		<p>68. Signature of jury: <i>John A. Smith</i></p>	
<p>69. Signature of jury: <i>John A. Smith</i></p>		<p>70. Signature of jury: <i>John A. Smith</i></p>	
<p>71. Signature of jury: <i>John A. Smith</i></p>		<p>72. Signature of jury: <i>John A. Smith</i></p>	
<p>73. Signature of jury: <i>John A. Smith</i></p>		<p>74. Signature of jury: <i>John A. Smith</i></p>	
<p>75. Signature of jury: <i>John A. Smith</i></p>		<p>76. Signature of jury: <i>John A. Smith</i></p>	
<p>77. Signature of jury: <i>John A. Smith</i></p>		<p>78. Signature of jury: <i>John A. Smith</i></p>	
<p>79. Signature of jury: <i>John A. Smith</i></p>		<p>80. Signature of jury: <i>John A. Smith</i></p>	
<p>81. Signature of jury: <i>John A. Smith</i></p>		<p>82. Signature of jury: <i>John A. Smith</i></p>	
<p>83. Signature of jury: <i>John A. Smith</i></p>		<p>84. Signature of jury: <i>John A. Smith</i></p>	
<p>85. Signature of jury: <i>John A. Smith</i></p>		<p>86. Signature of jury: <i>John A. Smith</i></p>	
<p>87. Signature of jury: <i>John A. Smith</i></p>		<p>88. Signature of jury: <i>John A. Smith</i></p>	
<p>89. Signature of jury: <i>John A. Smith</i></p>		<p>90. Signature of jury: <i>John A. Smith</i></p>	
<p>91. Signature of jury: <i>John A. Smith</i></p>		<p>92. Signature of jury: <i>John A. Smith</i></p>	
<p>93. Signature of jury: <i>John A. Smith</i></p>		<p>94. Signature of jury: <i>John A. Smith</i></p>	
<p>95. Signature of jury: <i>John A. Smith</i></p>		<p>96. Signature of jury: <i>John A. Smith</i></p>	
<p>97. Signature of jury: <i>John A. Smith</i></p>		<p>98. Signature of jury: <i>John A. Smith</i></p>	
<p>99. Signature of jury: <i>John A. Smith</i></p>		<p>100. Signature of jury: <i>John A. Smith</i></p>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Mar Park</u>		d. STREET ADDRESS <u>15212 Augusta St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Congressional Manor San.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>E</u> Last <u>Dellinger</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Front Royal, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Dellinger</u>		14. MOTHER'S MAIDEN NAME <u>Alvaretta Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marylyn D. Beall</u> Address <u>15212 Augusta St. Glenn Mar Park MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>uremia, terminal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>nephrosclerosis, advanced</u> DUE TO <u>1 yr.</u> (c) <u>arteriosclerosis, general, severe</u> DUE TO <u>10 yrs +</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thromboses, multiple</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 21, 1959</u> to <u>May 22, 1959</u> , that I last saw the deceased alive on <u>May 21, 1959</u> , and that death occurred at <u>11:45 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St. Wash 15 DC</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>5/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dellinger Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Naturalist Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home, Wash DC</u>		24. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles A. Purnell</u>			

5761 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Washington</i> b. COUNTY <i>Stevens</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chewelah</i> 84 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9612 Glencrest Lane</i>		d. STREET ADDRESS <i>111 W. Colville Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Della E Dunlap</i>		4. DATE OF DEATH <i>May 29 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/10/78</i>
9. AGE (In years last birthday) <i>80</i>		IF UNDER 1 YEAR <i>5</i> Months <i>19</i> Days <i>14</i> Hours <i>Min.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Montano</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John Henry Evans</i>		14. MOTHER'S MAIDEN NAME <i>Clara Peters.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>333-05-08970</i>	
17. INFORMANT <i>Hellen Peters</i>		Address <i>9612 Glencrest Ln</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>—</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month <i>May</i> Day <i>12</i> Year <i>1959</i> Hour o. m. <i>None</i> p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 12, 1959</i> , to <i>present</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>May 25, 1959</i> , and that death occurred at <i>5 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Umhau</i> M.D.		ADDRESS (Street, city or town, state) <i>8805 Conn Ave</i> DATE SIGNED <i>5/29/59</i>	
PHYSICIAN'S NAME (Type) <i>JOHN B. UMHAU</i>		<i>CHEXY CHASE MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-1-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR <i>JUN 2 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5762 CERTIFICATE OF DEATH

05740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN TB 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christian Eichen		4. DATE OF DEATH Month May Day 8 Year 1959	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber (self em.)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War I		16. SOCIAL SECURITY NO.	
17. INFORMANT Victoria Maria Neduhall Rt. 32 Clarksville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of the stomach with } abdominal metastases (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10, 1958 , to May 8, 1959 , that I last saw the deceased alive on May 8, 1959 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles S. Whitaker		ADDRESS (Street, city or town, state) Clarksville, Maryland	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		DATE SIGNED 5-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/12/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR MAY 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kimes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Howard H. Hubbard 4107 Wilkens Ave.

Barrel

5/12/59

London Park Cemetery, Baltimore, Maryland

May 25, 1959, N.D.

Clarksville, Maryland

Nov 59

October 10, 59

May 59

59

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Maryland

5763

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05741

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u> 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yorktown Village</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
c. LENGTH OF STAY IN 1b <u>1 hr. 15 min</u>		d. STREET ADDRESS <u>4100 W St. N.W. apt 411</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5104 Worthington Dr. Wash DC</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Tairo Andrew Erickson</u>		4. DATE OF DEATH <u>May 1 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. FUNDER 1 YEAR <u>Months</u> Days <u>Hours</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Security Officer</u>	
11. BIRTHPLACE (State or foreign country) <u>MICH</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Auro Erickson (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/4/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>TH+L. MEMORIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax County Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons Inc.</u>		24a. REC'D BY REGISTRAR <u>1756 Penna. Ave. N.W.</u>	
		24b. REGISTRAR'S SIGNATURE <u>DATE MAY 5 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5753

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10753

NAME OF DECEASED (Print Name)		AGE (Years)		SEX (Male or Female)		RACE (White, Colored, Chinese, Japanese, etc.)	
DATE OF DEATH (Month, Day, Year)		PLACE OF DEATH (City, State, Country)		OCCUPATION (If any)		EDUCATION (If any)	
CAUSE OF DEATH (State immediately and briefly)		MANNER OF DEATH (Natural, Accidental, Suicidal, Homicidal, Undetermined)		DISEASES (List all diseases, conditions, or injuries which contributed to death)		TREATMENT (List all medical treatment received)	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER	
SIGNATURE OF WITNESS		DATE OF WITNESSING		PLACE OF WITNESSING		NAME OF WITNESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5764 CERTIFICATE OF DEATH

Reg. Dist. No.

05742

1. PLACE OF DEATH COUNTY Montgomery MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland, Montgomery b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b X Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4901 Rugby Avenue		d. STREET ADDRESS 4901 Rugby Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SADIE I. FEESER		4. DATE OF DEATH Month Day Year May 21, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1879
9. AGE (In years last birthday) 79	10. IF UNDER 1 YEAR Months Days Hours Min. 10 3	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Brooklyn, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown (Maneely)		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No - - - - -		16. SOCIAL SECURITY NO. Yes	
INFORMANT Curtis S. Feeser - Item #2-husband		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Cerebral arteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH See Minks ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 52 to May 21 59 , that I last saw the deceased alive on May 20 59 , and that death occurred at 9:35 M, from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE George A. Pumphrey M.D.		ADDRESS (Street, city or town, state) 104 Chevy Chase Drive, 5/21/59	
PHYSICIAN'S NAME (Type) George A. Pumphrey, M.D.		15, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		24a. REC'D BY REGISTRAR MAY 25 '59	
ADDRESS Robert A. Pumphrey, Bethesda 14, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

45705

CENTRICATE OF DEATH

Residence

Bellevue

4001 Rusk Avenue

RESIDER

May 21

SADLER

July 10, 1970

White

Brooklyn, N. Y.

East House

Noted

(Signature)

(Signature)

Robert A. Puchner, 1225 25th Avenue

Yes

No

Robert A. Puchner, 1225 25th Avenue

Robert A. Puchner, 1225 25th Avenue

Robert A. Puchner, 1225 25th Avenue

Robert A. Puchner, 1225 25th Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05743

5713 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, 16 17 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital				d. STREET ADDRESS 7423 Aspen Court,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Fenn				4. DATE OF DEATH Month Day Year May 5, 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1959	
9. AGE (In years lost birthday) yrs. 6		IF UNDER 1 YEAR Months Days Hours Min 55		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) America		12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Richard Lee Fenn		14. MOTHER'S MAIDEN NAME Joan Rebecca Witteman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. father		17. INFORMANT father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia neonatorum 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Winston E. Cochran M.D.				927 Pershing Dr., Silver Spring, Md.			
PHYSICIAN'S NAME (Type) Winston E. Cochran, M. D.				927 Pershing Dr., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5-5-59		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital Takoma Park, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D.				ADDRESS Washington Sanitarium and Hospital, Takoma Park, Maryland		24a. REC'D BY REGISTRAR Arthur S. Hare	
24b. REGISTRAR'S SIGNATURE Arthur S. Hare				DATE MAY 7 '59			

5714

CERTIFICATE OF DEATH

05744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. 47x-3 b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fair Hill Rest Home 207 Hudson Ave.				d. STREET ADDRESS 3900 14th St. N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sarah Middle Jane Last Fischer				4. DATE OF DEATH Month May Day 1 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2/19/82	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William H. Forrest				14. MOTHER'S MAIDEN NAME Carrie M. Sauers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT George A. Fischer Address 2714 31st St. S.E. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Generalized Arteriosclerosis (c) Hypertension with thickening INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2:30 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Takoma Park	
20f. (City or town) Washington, D.C.				20g. (County) Montgomery		20h. (State) Maryland	
21. I certify that I attended the deceased from January 1959 , to April 30th 1959 , that I last saw the deceased alive on April 30 1959 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8700 Calverville Rd Silver Spring Md 20914 DATE SIGNED May 1, 1959							
ACTUAL SIGNATURE Lysle Williams				M.D. Lysle Williams M.D.			
PHYSICIAN'S NAME (Type) Lysle Williams M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/4/59		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.				24a. REC'D BY REGISTRAR MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH A. HOME		MAYLAND	
STREET OR ROAD TO WHICH DEATH OCCURRED B. PLACE OF DEATH		STREET OR ROAD TO WHICH DEATH OCCURRED	
CITY OR TOWN		CITY OR TOWN	
COUNTY		COUNTY	
STATE		STATE	
DATE OF DEATH		DATE OF DEATH	
HOURS		HOURS	
MINUTES		MINUTES	
AGE		AGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
MARRIAGE		MARRIAGE	
RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF DEATH REGISTRAR	
OFFICIAL SEAL		OFFICIAL SEAL	

5765

CERTIFICATE OF DEATH

Reg. Dist. No. 05746

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 19 hrs. 50 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Chester Middle Lawrence Last Fordney		4. DATE OF DEATH Month May Day 26 Year 19 59	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1892
9. AGE (In years lost birthday) yrs. 66		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY USMC	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Warren Fordney		14. MOTHER'S MAIDEN NAME Kathryn Haaren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW-1 & WW-2	
17. INFORMANT Mrs. Dorothy Fordney (Wife)		Address Hamilton, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 443x DUE TO (b) hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) ?			INTERVAL BETWEEN ONSET AND DEATH 20 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 25 , 19 59 to May 26 , 19 59 , that I last saw the deceased alive on May 26 , 19 59 , and that death occurred at 6:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. _____	
PHYSICIAN'S NAME (Type) F. J. LINEHAN JR., LCDR MCUSN		U. S. Naval Hospital, Bethesda, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Muse and Reed		24a. REC'D BY REGISTRAR JUN 1 '59	
ADDRESS Leesburg, Virginia		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05750

5705 : CERTIFICATE OF DEATH

DATE

TIME

PLACE

DECEASED

AGE

SEX

RESIDENCE

CAUSE

DATE

TIME

PLACE

SEX

DECEASED

CAUSE

DATE

TIME

PLACE

SEX

DECEASED

CAUSE

DATE

TIME

PLACE

SEX

DECEASED

CAUSE

DATE

TIME

PLACE

SEX

5766 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>			d. STREET ADDRESS <u>CIRCLE DRIVE, GLEN HILLS</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>ISABEL</u> Middle <u>LIVINGSTONE</u> Last <u>FOX</u>			4. DATE OF DEATH Month <u>5</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/22/1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WALTER WOLSTENHOLM</u>			14. MOTHER'S MAIDEN NAME <u>SARAH BAQSHAW-WOLSTENHOLM</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-22-8074</u>	INFORMANT <u>CLIFFORD LIVINGSTONE</u> Address <u>1501 S. 28th ST. APT. 6 ARLINGTON, VA.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma c Metastatic</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3 May</u> , 19 <u>59</u> , and that death occurred at <u>12:15 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SMAY 59</u> DATE SIGNED ACTUAL SIGNATURE <u>Marvin M. Gibson</u> M.D. <u>809 Viers mill Rd.</u> PHYSICIAN'S NAME (Type) <u>MARVIN M. GIBSON</u> <u>Rockville, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Mausoleum</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda 14, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>MAY 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05748	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>SENECA MD.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(POTOMAC RIVER)</u> c. LENGTH OF STAY IN 1b <u>5767</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u> d. STREET ADDRESS <u>2206 Cherri Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>E</u> Middle <u>Froendt</u> Last 4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1959</u>					5. SEX <u>M.</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 30, 1929</u> 9. AGE (In years last birthday) <u>30</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U S Army</u> 11. BIRTHPLACE (State or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>unk</u>					14. MOTHER'S MAIDEN NAME <u>unk</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>unk</u>					17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning -</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Motor boat he was driving swamped in mid river, and he was unable to swim to shore</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Motor boat he was driving swamped in mid river, and he was unable to swim to shore</u>						
20c. TIME OF INJURY Month, Day, Year <u>7:30</u> a. m. <u>May 2, 59</u> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River</u>	20f. (City or town) (County) (State) <u>Seneca Montg. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John G. Bell</u> EXAMINER'S NAME (Type) <u>John G. Bell</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7 May 1959</u> DATE SIGNED						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>May 12, 1959</u>					22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>					ADDRESS <u>816 H ST. N.E. WASH DC.</u>					24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kuntz</u>



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15

2

65742

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5767

NEW STATE
HEALTH DEPT



7936. Old Supreme Rd

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

5768

CERTIFICATE OF DEATH

05749

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Germantown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Cornelius</u> First <u>Martin</u> Middle <u>Frye</u> Last				4. DATE OF DEATH <u>May - 25 - 1959</u> Month <u>May</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-23-1872</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Rail Road</u>		11. BIRTHPLACE (State or foreign country) <u>London Co., Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Idella Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-07-7544</u>		17. INFORMANT <u>Ruth V. Frye, Rural Germantown, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral accidents (405)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mental deterioration</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from _____, 1954, to <u>May - 25 - 1959</u> , that I last saw the deceased alive on <u>May - 24 - 1959</u> , and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Miller</u> M.D. <u>7 - Brooks Ave.,</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u> <u>Gaithersburg, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Rose Cemetery</u>	22d. LOCATION (City, town, or county) <u>Gaithersburg, Md.</u> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. G. Gattner</u> ADDRESS <u>316 E. Diamond Ave. Gaithersburg, Md.</u>				24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur S. French</u>		
DATE <u>JUN 1 '59</u>							

CERTIFICATE OF DEATH

Decedent - *William C. Miner*
Age - *70*
Sex - *Male*

Place of Birth - *Germany*
Date of Birth - *May 22 - 01*

Residence - *1400 E. North Ave., Baltimore, Md.*
Cause of Death - *Heart Disease*
Date of Death - *Oct 23 - 1922*

Place of Death - *Home*
Physician - *Dr. J. H. Smith*
Burial - *Yes*

Medical Certificate

Witnesses - *William C. Miner*
Date - *May 22 - 01*
Signature - *W. C. Miner*

5769 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 31 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 936 Madison Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roscoe Middle Flabious Last GRADY				4. DATE OF DEATH Month May Day 15 Year 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-22-91	
				9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) No. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jones GRADY				14. MOTHER'S MAIDEN NAME Mary Jane (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 579 05 9631		17. INFORMANT Mrs. Amy Grady (Wife), same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 550.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c) Bot Op Appendicitis with perforation							INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 14 , 19 59 , to May 15 , 19 59 , that I last saw the deceased alive on May 15 , 19 59 , and that death occurred at 9:50P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Troy				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 5-16-59			
PHYSICIAN'S NAME (Type) John W. TROY, CDR, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chmaber's ADDRESS 1400 Chapin St., N.W., Wash, DC				24a. REC'D BY REGISTRAR MAY 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

10-750

<p>NAME OF DECEASED J. B. JONES</p>		<p>DATE OF DEATH JAN 12 1925</p>	
<p>AGE 45</p>		<p>SEX M</p>	
<p>PLACE OF BIRTH BALTIMORE, MD.</p>		<p>RESIDENCE BALTIMORE, MD.</p>	
<p>OCCUPATION Carpenter</p>		<p>CAUSE OF DEATH Heart Disease</p>	
<p>IMMEDIATE CAUSE OF DEATH Myocardial Infarction</p>		<p>PERMANENT CAUSE OF DEATH Atherosclerosis</p>	
<p>DATE OF INTERMENT JAN 15 1925</p>		<p>PLACE OF INTERMENT St. John's Cemetery</p>	
<p>SIGNATURE OF PHYSICIAN J. B. JONES</p>		<p>SIGNATURE OF REGISTRAR J. B. JONES</p>	
<p>DATE OF SIGNATURE JAN 12 1925</p>		<p>DATE OF SIGNATURE JAN 12 1925</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5770

CERTIFICATE OF DEATH

05751

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8324 - 16th STREET</u>		d. STREET ADDRESS <u>18324 - 16th STREET.</u>	
3. NAME OF DECEASED (Type or print) <u>MILDRED ROWLEY GRAHAM</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 28, 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISCAL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. OF JUSTICE</u>	11. BIRTHPLACE (State or foreign country) <u>ELMIRA, NEW YORK</u>
13. FATHER'S NAME <u>TIMOTHY ROWLEY</u>		14. MOTHER'S MAIDEN NAME <u>MABLE HORTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-09-6965</u>	
17. INFORMANT <u>JOHN W. GRAHAM, 8324 16th ST. S.S. MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pneumonia heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>30 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Tele</u> , 19 <u>58</u> to <u>May 13, 1959</u> , that I last saw the deceased alive on <u>May 9, 1959</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. Kreuzburg</u>		ADDRESS (Street, city or town, state) <u>7852 16th St NW</u>	
PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>		DATE SIGNED <u>5/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 18, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Canal St NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 15 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5771

CERTIFICATE OF DEATH

05752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1210 Highland Drive		d. STREET ADDRESS 1210 Highland Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Mathew Last Gullick		4. DATE OF DEATH Month May Day 2 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/1887
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Gullick		14. MOTHER'S MAIDEN NAME Susan Kushner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.1		16. SOCIAL SECURITY NO.	
17. INFORMANT Milton P. Birthright-8712 Colesville Rd.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 5, 1956 , to May 2, 1957 , that I last saw the deceased alive on May 2/6 1957 , and that death occurred at 11 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7852 16th St NW DATE SIGNED 5/2/59			
ACTUAL SIGNATURE H F Kreuzburg		M.D. Wash D C	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/6/59	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery
		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE MAY 5 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

02585

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05753

5772 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Logan 85 x 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS General Delivery			
3. NAME OF DECEASED (Type or print) First Howard Middle James Last Hager				4. DATE OF DEATH Month May Day 29 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1907		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jim Hager				14. MOTHER'S MAIDEN NAME Cora Kenser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 236-03-9539		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphocytic Leukemia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from March 13 , 19 59 , to May 29 , 19 59 , that I last saw the deceased alive on May 29 , 19 59 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-30-59 ACTUAL SIGNATURE Nathan S. Taylor M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 5/30/59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Logan, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5773

CERTIFICATE OF DEATH

Reg. Dist. No. 05754

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle W. Last HAMILTON		4. DATE OF DEATH Month May Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wallace Hamilton		14. MOTHER'S MAIDEN NAME Alice Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Florence Hebron 4507 Rhode Island, Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Generalized DUE TO (c) 4 years INTERVAL BETWEEN ONSET AND DEATH 10 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 54 , to 8 May , 19 59 , that I last saw the deceased alive on 8 May , 19 59 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 8 May 59 ACTUAL SIGNATURE Gordon M. Smith M.D. Baltimore, Md. PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/12/59	
22c. NAME OF CEMETERY OR CREMATORY Elijah,		22d. LOCATION (City, town, or county) (State) Poolesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24a. REC'D BY REGISTRAR DATE MAY 14 '59	
ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

08751

Name of Deceased		Date of Death	
John J. Smith		Jan 15, 1913	
Age		35	
Sex		Male	
Place of Birth		Boston, Mass.	
Cause of Death		Heart Disease	
Occupation		Teacher	
Residence		123 Main St., Boston	
Signature of Physician		J. B. Smith	
Signature of Registrar		A. B. Jones	

5774

Item 1c Film G243 6-3-59 et

CERTIFICATE OF DEATH

05755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>43 AM days</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Frederica</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>46 X - 3</u> d. STREET ADDRESS <u>Ocean Drive Manor</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Della Angeline Harden</u>				4. DATE OF DEATH Month Day Year <u>May 29, 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 31, 1897</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Midwife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>			
13. FATHER'S NAME <u>Enoch Ferrell</u>				14. MOTHER'S MAIDEN NAME <u>Florence Neuzum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion + Atelectasis</u> <u>2040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Lymphocytic Leukemia</u> DUE TO (c) <u>12-14 mos.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12-14 mos.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 16, 1959</u> , to <u>May 29, 1959</u> , that I last saw the deceased alive on <u>May 29, 1959</u> , and that death occurred at <u>11:58 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Habeeb Bacchus</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Habeeb Bacchus, M. D.</u>				DATE SIGNED <u>5-30-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Inter & Burial</u>		22b. DATE THEREOF <u>6-2-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catawba W. Va</u>		22d. LOCATION (City, town, or county) (State) <u>Catawba W. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Pumphrey</u>				24a. REC'D BY REGISTRAR <u>7557 Wisc Ave Beth Md</u>			
24b. REGISTRAR'S SIGNATURE <u>June 2 59</u>				24c. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

1 M 050 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 M 050 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5775 CERTIFICATE OF DEATH

Reg. Dist. No.

05756

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 49 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Jo Last Harrison				4. DATE OF DEATH Month May Day 10 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1907	
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Manager Loan Dept.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William M. Moran				14. MOTHER'S MAIDEN NAME Marion Kinter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acoustic Neuroma, left DUE TO Chronic Pyelonephritis, bilateral DUE TO Pneumopneumonia, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 223X				INTERVAL BETWEEN ONSET AND DEATH 1-2 years 1-2 years 24 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 22, 1959 , to May 10, 1959 , that I last saw the deceased alive on May 10, 1959 , and that death occurred at 8:25 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/10/59			
PHYSICIAN'S NAME (Type) EDWARD J. LASKOWSKI, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/13/59		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE MAY 15 '59		24b. REGISTRAR'S SIGNATURE [Signature]	

62732

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

REG. DIST. NO.

DECEASED'S NAME (Last, first, middle initial)

MARRIAGE

DATE OF BIRTH (Month, day, year)

PLACE OF BIRTH (City, State, Country)

DATE OF DEATH (Month, day, year)

TIME OF DEATH (Hour, minute)

PLACE OF DEATH (City, State, Country)

CAUSE OF DEATH (Disease, injury, etc.)

DATE OF INTERMENT (Month, day, year)

PLACE OF INTERMENT (City, State, Country)

DATE OF BURIAL (Month, day, year)

PLACE OF BURIAL (City, State, Country)

DATE OF CREMATION (Month, day, year)

PLACE OF CREMATION (City, State, Country)

DATE OF EXHUMATION (Month, day, year)

PLACE OF EXHUMATION (City, State, Country)

DATE OF REINTERMENT (Month, day, year)

PLACE OF REINTERMENT (City, State, Country)

DATE OF REBURYAL (Month, day, year)

PLACE OF REBURYAL (City, State, Country)

DATE OF RECREMATION (Month, day, year)

PLACE OF RECREMATION (City, State, Country)

DATE OF REEXHUMATION (Month, day, year)

PLACE OF REEXHUMATION (City, State, Country)

DATE OF REINTERMENT (Month, day, year)

PLACE OF REINTERMENT (City, State, Country)

DATE OF REBURYAL (Month, day, year)

PLACE OF REBURYAL (City, State, Country)

DATE OF RECREMATION (Month, day, year)

PLACE OF RECREMATION (City, State, Country)

DATE OF REEXHUMATION (Month, day, year)

PLACE OF REEXHUMATION (City, State, Country)

DATE OF REINTERMENT (Month, day, year)

PLACE OF REINTERMENT (City, State, Country)

DATE OF REBURYAL (Month, day, year)

PLACE OF REBURYAL (City, State, Country)

DATE OF RECREMATION (Month, day, year)

PLACE OF RECREMATION (City, State, Country)

DATE OF REEXHUMATION (Month, day, year)

PLACE OF REEXHUMATION (City, State, Country)

DATE OF REINTERMENT (Month, day, year)

PLACE OF REINTERMENT (City, State, Country)

DATE OF REBURYAL (Month, day, year)

PLACE OF REBURYAL (City, State, Country)

DATE OF RECREMATION (Month, day, year)

PLACE OF RECREMATION (City, State, Country)

DATE OF REEXHUMATION (Month, day, year)

PLACE OF REEXHUMATION (City, State, Country)

DATE OF REINTERMENT (Month, day, year)

PLACE OF REINTERMENT (City, State, Country)

DATE OF REBURYAL (Month, day, year)

PLACE OF REBURYAL (City, State, Country)

DATE OF RECREMATION (Month, day, year)

PLACE OF RECREMATION (City, State, Country)

DATE OF REEXHUMATION (Month, day, year)

PLACE OF REEXHUMATION (City, State, Country)

DATE OF REINTERMENT (Month, day, year)

PLACE OF REINTERMENT (City, State, Country)

DATE OF REBURYAL (Month, day, year)

PLACE OF REBURYAL (City, State, Country)

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5776 CERTIFICATE OF DEATH

05757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Conemaugh c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1140 William Penn Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Agatha Last Harteis		4. DATE OF DEATH Month May Day 26 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) yrs. 33
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Webster Sweeney		14. MOTHER'S MAIDEN NAME Agatha McGuire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia heart disease - 410X DUE TO stroke embolization during Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) mitral commissurotomy DUE TO (c) mitral commissurotomy INTERVAL BETWEEN ONSET AND DEATH years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 17, 1959 to May 26, 1959 that I last saw the deceased alive on May 26, 1959 and that death occurred at 12:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-26-59 ACTUAL SIGNATURE William W. Pfaff M.D. The Clinical Center PHYSICIAN'S NAME (Type) William W. Pfaff, M.D. National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial	22b. DATE THEREOF 5/29/59	22c. NAME OF CEMETERY OR CREMATORY St. John, s Cem.	22d. LOCATION (City, town, or county) (State) Johnstown, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR MAY 28 1959 DATE 24b. REGISTRAR'S SIGNATURE Arthur A. Pugh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00757

CERTIFICATE OF DEATH

3778

Name of Deceased		Age		Sex		Race		Color	
John A. Johnson		37		Male		White		White	
Date of Death		Place of Death		Cause of Death		Disease		Manner of Death	
May 15, 1950		Home		Heart Disease		Myocardial Infarction		Natural	
Time of Death		Physician		Hospital		Burial Place		Burial Date	
10:30 AM		Dr. J. H. Smith		St. John's Hospital		St. John's Cemetery		May 17, 1950	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	
Date of Issuance		Place of Issuance		Cause of Issuance		Disease		Manner of Issuance	
May 16, 1950		Baltimore, MD		Death Certificate		Myocardial Infarction		Natural	
Signature of Registrar		Signature of Coroner		Signature of Burial Officer		Signature of Witness		Signature of Physician	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	
Date of Issuance		Place of Issuance		Cause of Issuance		Disease		Manner of Issuance	
May 16, 1950		Baltimore, MD		Death Certificate		Myocardial Infarction		Natural	
Signature of Registrar		Signature of Coroner		Signature of Burial Officer		Signature of Witness		Signature of Physician	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	



5777 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5100 T Street, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Edward HEINEMAN			4. DATE OF DEATH Month May Day 6 Year 19 59				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-86	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Pennsylvania			
13. FATHER'S NAME Christian HEINEMAN			14. MOTHER'S MAIDEN NAME Fanny EIKEE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes 1902 - 1945		16. SOCIAL SECURITY NO. 579-14-6019		17. INFORMANT Address (W) Mrs. Stella Heineman, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and infection 4444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 months 10 years Indef.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from April 27 , 19 59 , to May 6 , 19 59 , that I last saw the deceased alive on May 6 , 19 59 , and that death occurred at 8:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 4-7-59							
ACTUAL SIGNATURE J. M. Young		PHYSICIAN'S NAME (Type) J. M. YOUNG, LT, MC, USN					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-12-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National			
22d. LOCATION (City, town, or county) Arlington		22e. (State) Virginia		22f. REC'D BY REGISTRAR MAY 8 '59			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 517 11th St., S.E., Washington, DC		24b. REGISTRAR'S SIGNATURE Arthur S. Howard					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5778 CERTIFICATE OF DEATH

Reg. Dist. No. 05759

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>28 1/2 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>6102 SWANSEA ST.</u>	

3. NAME OF DECEASED (Type or print) First <u>ERIC</u> Middle <u>HELLEKJAER</u> Last <u>HELLEKJAER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14, 1959</u>
9. AGE (In years last birthday) <u>1</u> yr. <u>1</u> month <u>1</u> day <u>1</u> hour <u>1</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13. FATHER'S NAME <u>PER HELLEKJAER</u>	14. MOTHER'S MAIDEN NAME <u>MARY JANE SELLECK</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Per Hellekjaer - 6102 - Swansea St.</u>	Address <u>Bethesda</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis -</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Secondary prematurity</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>5/14</u> , 19 <u>59</u> , to <u>5/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Robert E. Stadelman</u> M.D.	ADDRESS (Street, city or town, state) <u>1717 N. St. N.W.</u> DATE SIGNED <u>5/16/59</u>
PHYSICIAN'S NAME (Type) <u>Robert E. Stadelman, M. D.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>5/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 19 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kinn</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1099344XVI

5012 Annual Financial and Statistical Information (with volume) (TC)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6199

CERTIFICATE OF DEATH

05760
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 26			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 908 Viers Mill Rd.				d. STREET ADDRESS 1724 Grandin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle MAY Last HENLEY				4. DATE OF DEATH Month May Day 23 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 5 Days 1	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Edward Henley				14. MOTHER'S MAIDEN NAME Elizabeth Butt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes		INFORMANT Arthur R. Henley Nephew		Address Damascus, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Wema Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertension DUE TO ASCVD (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 wk 5 yrs Undetermined
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C. 4. 7.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/1, 1952 , to 5/23, 1957 , that I last saw the deceased alive on 5/23, 1959 , and that death occurred at 1:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones		M.D. Rockville, Md.		ADDRESS (Street, city or town, state) 809 Viers Mill Rd. Rockville, Maryland		DATE SIGNED 5/24/59	
PHYSICIAN'S NAME (Type) Stephen N. Jones							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-59		22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. French	

05368

CERTIFICATE OF DEATH

7193

Rockville	Montgomery	Maryland	Montgomery
908 Vista Hill Rd.			
10A	10A	10A	10A
Female	White	Dec. 22, 1988	70
Rockville	Long home	Maryland	U. S.
Edward Henry			
No	Yes	Arthur N. Henry	Montgomery, Maryland

Stephen N. Jones	Rockville, Maryland	5-24-88
5-24-88	Rockville, Maryland	5-24-88
Robert A. Lumsden	Rockville, Maryland	5-24-88

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5779

CERTIFICATE OF DEATH

Reg. Dist. No. 05761

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Molly</u> Middle <u>M.</u> Last <u>HENRY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>19 59</u>	
5. SEX <u>7c</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>6</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Clark</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Kearmf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>526x Pulmonary Hemorrhage</u> DUE TO (b) <u>Bronchitis</u> DUE TO (c) <u>Chronic Bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15</u> <u>Indef.</u> <u>Indef.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>gen. arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1, 1958</u> to <u>May 8, 1959</u> that I last saw the deceased alive on <u>5/8/59</u> 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>5/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		<u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>5/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmal Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berkley Co. W. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

05301

CERTIFICATE OF DEATH

2578

My name is William A. Jones
I am 25 years of age
I was born July 1, 1900
at St. Louis, Mo.

My name is William A. Jones
I am 25 years of age
I was born July 1, 1900
at St. Louis, Mo.

My name is William A. Jones
I am 25 years of age
I was born July 1, 1900
at St. Louis, Mo.

My name is William A. Jones
I am 25 years of age
I was born July 1, 1900
at St. Louis, Mo.

My name is William A. Jones
I am 25 years of age
I was born July 1, 1900
at St. Louis, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5780

CERTIFICATE OF DEATH

05762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Washington D.C. 12 months + Rural - Washington D.C.)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5220 Marilyn Drive, Glenman Pk.</u>				e. STREET ADDRESS <u>5220 Marilyn Dr. Glenman Pk.</u>			
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>Daniel</u> Last <u>Higgins</u>				4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 24, 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer (farm)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Simpson, Minn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Higgins</u>				14. MOTHER'S MAIDEN NAME <u>Donative</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Son</u> Address <u>5220 Glenman Pk.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastroc dilatation</u> <u>544.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral thrombosis</u> DUE TO (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>May 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 30</u> , 19 <u>59</u> , and that death occurred at <u>10:57 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantrant</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantrant</u>				DATE SIGNED <u>5/14/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>Wash. D. C. 3821 14th. St. N.W.</u>				24a. REC'D BY REGISTRAR <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. A. & H. A.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

5280

5280

21
11/20/02

x

10/24/02
890 Botta
Juv

10/24/02
890 Botta
Juv

5781

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				d. STREET ADDRESS 9616 Old Spring Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN HUBBARD HOLCH				4. DATE OF DEATH Month Day Year May 1, 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1875	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 5 Days 26	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Geneologist		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Hiram Wilbur Hubbard				14. MOTHER'S MAIDEN NAME Josephene Ferguson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address W.R.F. Adams-sin-in-law-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) * patient under medical supervision (other than my own) at nursing home for 1 yr.						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from May 1 , 19 59 , to May 1 , 19 59 , that I last saw the deceased alive on May 1 , 19 59 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10620 Georgia Ave. Silver Spring			
ACTUAL SIGNATURE Donald Nelson		M.D. 10620 Georgia Ave. Silver Spring		PHYSICIAN'S NAME (Type) Donald Nelson Maryland 5/1/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/4/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

00328

5781

CERTIFICATE OF DEATH

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

Married, white, male, age 35, born 1898, died 1933, cause of death, heart disease.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Items 18-21 Film 245 8-16-59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05764

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> 5782 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>18 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10512 Lorraine Ave</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>10512 Lorraine Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thaddeus Leroy Hopkins</u> First Middle Last 4. DATE OF DEATH <u>May 20 1959</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-5-1901</u> 9. AGE (In years last birthday) <u>58</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>more projection</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Wm F. Hopkins</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Hankford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Wm F. Hopkins</u> 17. INFORMANT <u>101 S. Hampton Dr Silver Spring md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u> <u>871.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>871.9</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been taking considerable medication for arthritis</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DATE SIGNED <u>5-20-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUN. Home 4812 Ga Ave NW</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 3 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MEDICAL CERTIFICATION

15

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5726

CERTIFICATE OF DEATH

Reg. Dist. No.

05765

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 26		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 802 Roxboro Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLIFORD L. HOWARD		4. DATE OF DEATH Month May Day 22 Year 19 59		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-15-24		9. AGE (In years last birthday) 35 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Cliford L. Howard		14. MOTHER'S MAIDEN NAME Lucie Gallaher		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. Yes		17. INFORMANT Catherine G. Howard - Item #2- Wife		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 15 min		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 1958 to 5-22 , 19 59 , that I last saw the deceased alive on 5/22 , 19 59 , and that death occurred at 11 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. Rockville, Md.		DATE SIGNED 5-22-59	
ACTUAL SIGNATURE W. G. Hall		PHYSICIAN'S NAME (Type) W. G. Hall, 615 W. Montgomery Ave., Rockville, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-59		22c. NAME OF CEMETERY OR CREMATORY Darnestown Presby. Ch. Cem - Montgomery Co., Md.		22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR DATE MAY 27 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25. (City or town) (County) (State)		26. (City or town) (County) (State)		27. (City or town) (County) (State)		28. (City or town) (County) (State)		29. (City or town) (County) (State)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5783 CERTIFICATE OF DEATH

05766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 56 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 424 SOUTHWEST DRIVE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 424 SOUTHWEST DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTHER Middle O. Last IANNIELLO		4. DATE OF DEATH Month MAY Day 21 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/78
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VINCENT OLIVIERI		14. MOTHER'S MAIDEN NAME JUSTINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Harold E. Cropper, 424 Southwest Drive Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 - acute coronary occlusion DUE TO - arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1.5 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 4-1³⁰ , 19 59 , to 5-21¹² , 19 59 , that I last saw the deceased alive on 5-21¹² , 19 59 , and that death occurred at 9:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Veronika Troost M.D. 5-22-1959 PHYSICIAN'S NAME (Type) VERONIKA TROOST			
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF 5/25/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR SILVER SPRING, MD. DATE MAY 26 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

CERTIFICATE OF DEATH 2753

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES M. HENRY		M		45		JAN 15 1880		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
Carpenter		High School		Married		JAN 15 1905		BALTIMORE		MD		USA			
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Heart Failure		Natural		3 weeks		JAN 10 1925		BALTIMORE		MD		USA			
SIGNS AND SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS		CITY		STATE		COUNTRY	
Chest pain, shortness of breath, swelling of feet		Digitalis, nitroglycerin		None		JAN 1 1925		BALTIMORE		MD		USA			
FAMILY HISTORY		SOCIAL HISTORY		HABITS		RELIGION		RACE		COLOR		COMPLEXION		HAIR	
None		None		None		Catholic		White		White		Fair		Brown	
EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
High School		Married		JAN 10 1925		BALTIMORE		MD		USA					
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
Carpenter		High School		Married		JAN 15 1905		BALTIMORE		MD		USA			
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Heart Failure		Natural		3 weeks		JAN 10 1925		BALTIMORE		MD		USA			
SIGNS AND SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS		CITY		STATE		COUNTRY	
Chest pain, shortness of breath, swelling of feet		Digitalis, nitroglycerin		None		JAN 1 1925		BALTIMORE		MD		USA			
FAMILY HISTORY		SOCIAL HISTORY		HABITS		RELIGION		RACE		COLOR		COMPLEXION		HAIR	
None		None		None		Catholic		White		White		Fair		Brown	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5784

CERTIFICATE OF DEATH

Reg. Dist. No.

05767

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG		c. LENGTH OF STAY IN 1b 11 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REST HAVEN CONVALESCENT HOME		e. STREET ADDRESS 410 BROWN STREET	
		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Arthur Middle M Last Isherwood		4. DATE OF DEATH Month MAY Day 3 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/84
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	11. IF UNDER 24 HRS. Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR (retired)		10b. KIND OF BUSINESS OR INDUSTRY Highway Dept.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT ISHERWOOD		14. MOTHER'S MAIDEN NAME ISABELLA DARBY	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Mrs. Ruth K. Isherwood, 410 Brown St.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Asthma DUE TO (c) Cerebral Arteriosclerosis, Hypertension		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1957 , 19 57 , to May 3 , 19 59 , that I last saw the deceased alive on April 30 , 19 59 , and that death occurred at 6 A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE Luciano I. Leal	DATE SIGNED 108 N. Frederick Ave.
PHYSICIAN'S NAME (Type) Luciano I. Leal Gaithersburg Md	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/6/59	22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR MAY 5 59	24b. REGISTRAR'S SIGNATURE Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

5715 CERTIFICATE OF DEATH

05768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>8402 Barron St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Sherman</u> Middle <u>Wesley</u> Last <u>Jack</u>				4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-4-94</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>William H. Jack</u>				14. MOTHER'S MAIDEN NAME <u>Mervie Mosher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive failure</u> DUE TO <u>Ventricular flutter</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Diabetes mellitus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 14, 1959</u> , to <u>May 2, 1959</u> , that I last saw the deceased alive on <u>May 12, 1959</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eino Magi</u>				DATE SIGNED <u>5/2/59</u>			
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				ADDRESS (Street, city or town, state) <u>918 University Blvd. E. Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Kline</u>				ADDRESS <u>254 Carroll St. N.W. D.C.</u>			
24a. REC'D BY REGISTRAR <u>MAY 4 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

80208

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF DEATH <i>Jan 15 1920</i>	
5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. DISEASE OR INJURY <i>Myocardial Infarction</i>		8. MEDICAL ATTENDANCE <i>Dr. J. Smith</i>	
9. PLACE OF BIRTH <i>Baltimore, Md.</i>		10. OCCUPATION <i>Teacher</i>	
11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. RELIGION <i>Methodist</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>	
15. SIGNATURE OF WITNESSES <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>	
27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
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51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>	
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99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. PLACE OF DEATH
6. CAUSE OF DEATH
7. DISEASE OR INJURY
8. MEDICAL ATTENDANCE
9. PLACE OF BIRTH
10. OCCUPATION
11. MARITAL STATUS
12. EDUCATION
13. RELIGION
14. SIGNATURE OF DECEASED
15. SIGNATURE OF WITNESSES
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100. SIGNATURE OF DECEASED

05769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 HR. 10 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DERWOOD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				d. STREET ADDRESS MELINDA RUSSELL NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA		First IDA		Middle -		Last JACKSON	
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/1880	
9. AGE (In years last birthday) yrs. 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN BOSWELL		14. MOTHER'S MAIDEN NAME ANNA PROCTOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day 4 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/4 , 19 59 , to 5/16 , 19 59 , that I last saw the deceased alive on 5/16 , 19 59 , and that death occurred at 1:10 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. Sandy S. Bird 5/17/59 PHYSICIAN'S NAME (Type) J. W. BIRD, M. D. SANDY SPRING, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/59		22c. NAME OF CEMETERY OR CREMATORY St. Calvary		22d. LOCATION (City, town, or county) (State) Spencerville Ind	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Shuman		ADDRESS Rockville Ind.		24a. REC'D BY REGISTRAR DATE MAY 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

VS A15 (4)
ISM 10/57

VS A15 (4)
ISM 10/57

CERTIFICATE OF DEATH

2388

1915

DECEASED

AGE

SEX

DATE

PLACE OF BIRTH

DATE OF BIRTH

TIME

DATE

CAUSE OF DEATH

DIAGNOSIS

TIME

PLACE OF DEATH

NAME OF PHYSICIAN

HOSPITAL RECORDS

DATE

TIME

TIME

DATE

TIME

REMARKS

DATE

TIME

REMARKS

REMARKS

REMARKS

REMARKS

DATE

TIME

REMARKS

REMARKS

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5786 CERTIFICATE OF DEATH

Reg. Dist. No. 05770

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>GORDON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>24 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>128 AMES ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUTISHA ELIZABETH JACKSON</u>				4. DATE OF DEATH Month Day Year <u>MAY 27 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 25, 1874</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William R. Lancaster</u>				14. MOTHER'S MAIDEN NAME <u>Betsy Ann Mahalia Pirkle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MARTHA MILLS</u>		Address <u>128 AMES RD, Silver Spring, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>195.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Pituitary Gland</u> DUE TO (c) <u>6 1/2 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Hyattsville, Md</u>				20g. (County) <u>Gordon Co.</u>		20h. (State) <u>Ga.</u>	
21. I certify that I attended the deceased from <u>DEC 27, 1957</u> to <u>MAY 27, 1959</u> , that I last saw the deceased alive on <u>MAY 25, 1959</u> , and that death occurred at <u>3:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James L. Laubach</u>				ADDRESS (Street, city or town, state) <u>1806 FOX ST, Hyattsville, Md</u>			
PHYSICIAN'S NAME (Type) <u>James L. Laubach</u>				DATE SIGNED <u>May 27th, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 28th, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oothoaloga Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gordon Co. near Adairsville, Ga.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>18 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3908 Mertford st</u>			d. STREET ADDRESS <u>3908 Mertford st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Milton</u> First <u>Jackson</u> Middle Last			4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>19 59</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-1904</u>		9. AGE (In years last birthday) <u>54</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Aqueduct Center</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.C</u>					
13. FATHER'S NAME <u>Benny Jackson</u>			14. MOTHER'S MAIDEN NAME <u>Amie Hall</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Rosie Jackson (wife)</u>			Address <u>Stur 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Rockville, Md.</u>		(County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-23-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>	
22d. LOCATION (City, town, or county) <u>Rockville, Md.</u>		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		1617-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooks Grove Foundation</u>				d. STREET ADDRESS <u>7311 Flower Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAUDE AGNES JENKINS</u>				4. DATE OF DEATH <u>May 11, 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		IF UNDER 1 YEAR	
		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Dickinson Center N.Y.</u>			
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wallace Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Elmira Clarke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>	
						Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema - acute</u> 7220 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Center-Far advanced Rheumatoid arthritis + Total Deformity</u> DUE TO (c) <u>20 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
						20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 1957, to <u>May</u> , 1959, that I last saw the deceased alive on <u>10 May</u> , 1959, and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.				ADDRESS (Street, city or town, state) <u>Alney Md</u>			
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>				DATE SIGNED <u>11 May 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 13, 1959</u>		<u>Eastwood Cemetery</u>		<u>South Lancaster, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>234 Calvert St. Washington, D.C.</u>		24. REC'D BY REGISTRAR <u>May 13 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

2788

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, OCT. 18

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05773

5789

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5077 Bradley Blvd. Bethesda</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5077 Bradley Blvd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Diane</u> Middle <u>YVONNE</u> Last <u>Jernigan</u>				4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1953</u>		9. AGE (In years last birthday) <u>5</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Senadi, Japan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis E. Jernigan</u>				14. MOTHER'S MAIDEN NAME <u>BETTY LOIS WOODWARD.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Louis E. Jernigan</u> Address <u>Item #2</u> <u>Parent</u> <u>As above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>551x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Encephalomalacia</u> (a), stating the underlying cause last. DUE TO (c) <u>Cardiac Arrest (During appendectomy)</u> INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u> <u>23 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pending</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Merrill M. Cross</u>				CHIEF MEDICAL EXAMINER: <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>MERRILL M. CROSS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Rockville, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg (Rural) c. LENGTH OF STAY IN lb 2 Months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashton d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle W Last Johnson		4. DATE OF DEATH Month May Day 18 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1879
9. AGE (In years and birth day) 79 yrs.		10. IF UNDER 1 YEAR Months 19 Days 59	11. IF UNDER 24 HRS. Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph H. Johnson		14. MOTHER'S MAIDEN NAME Emma Ann Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W.W. # 1		16. SOCIAL SECURITY NO. INFORMANT Sarah Johnson, Ashton, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Nephritis 600.2 DUE TO Infection of Chronic Nephritic Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) One kidney removed. (c) Nephritic Hypertension		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 21, 1936 , to May 18, 1959 , that I last saw the deceased alive on May 18, 1959 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5.20.59 DATE SIGNED 5.20.59			
ACTUAL SIGNATURE Webster Sewell M.D.		PHYSICIAN'S NAME (Type) Webster Sewell, M.D. Rt. 1 Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surnden Rockville, Md.		24a. REC'D BY REGISTRAR DATE MAY 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

103754

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5791

CERTIFICATE OF DEATH

Reg. Dist. No.

05775

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 56	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 18009 Eastern Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8009 Eastern Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary A. Middle Johnson Last		4. DATE OF DEATH Month May Day 3 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/71
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Sheppard		14. MOTHER'S MAIDEN NAME Alice Hampton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edith J. Brown same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA, LEFT LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS RT DUE TO (c) HYPERTENSIVE HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 1 1/2 years YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS GEN - CHRONIC PYELONEPHRITIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 19 to MAY 3 1959, that I last saw the deceased alive on MAY 3 1959, and that death occurred at 2:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Jacob Ceppos M.D.		4316-14725-111	
PHYSICIAN'S NAME (Type) JACOB CEPPOS, M.D.		WASHINGTON - D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 5/6/59	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE MAY 5 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5792 CERTIFICATE OF DEATH

Reg. Dist. No. 05776

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3117 Plyers Mill Rd.				e. STREET ADDRESS 3117 Plyers Mill Rd.			
3. NAME OF DECEASED (Type or print) First MARY Middle AGNES Last JOYCE				4. DATE OF DEATH Month MAY Day 9 Year 19-59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Richard O'Connor				14. MOTHER'S MAIDEN NAME Johanna Reidern			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas F. Joyce		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERIO SCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 MRS. 5 1/2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 1955 , 19____, to May 9 , 19 59 , that I last saw the deceased alive on May 9 , 19 59 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert T. Thibadeau M.D.				ADDRESS (Street, city or town, state) 10609 CONCORD ST. KENSINGTON, MD			
PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU				DATE SIGNED MAY 9-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/59		22c. NAME OF CEMETERY OR CREMATORY St. Josephs Cem		22d. LOCATION (City, town, or county) (State) East McKeesport, Penna	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAY 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss			

CERTIFICATE OF DEATH

10578

NAME OF DECEASED JAMES O'CONNOR		AGE 45		SEX Male		RACE White		RELIGION Catholic		MARRIAGE Married		EDUCATION High School		OCCUPATION None		DATE OF BIRTH June 19, 1906		PLACE OF BIRTH Ireland		DATE OF DEATH June 19, 1950		PLACE OF DEATH At home			
RESIDENCE 117 Myers Mill Rd. Baltimore, Md.		DATE OF DEATH June 19, 1950		TIME OF DEATH 10:30 AM		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		PREVIOUS ILLNESS Hypertension		TREATMENT None		DATE OF DEATH June 19, 1950		PLACE OF DEATH At home		DATE OF DEATH June 19, 1950		PLACE OF DEATH At home	
NAME OF DECEASED JAMES O'CONNOR		AGE 45		SEX Male		RACE White		RELIGION Catholic		MARRIAGE Married		EDUCATION High School		OCCUPATION None		DATE OF BIRTH June 19, 1906		PLACE OF BIRTH Ireland		DATE OF DEATH June 19, 1950		PLACE OF DEATH At home			
RESIDENCE 117 Myers Mill Rd. Baltimore, Md.		DATE OF DEATH June 19, 1950		TIME OF DEATH 10:30 AM		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		PREVIOUS ILLNESS Hypertension		TREATMENT None		DATE OF DEATH June 19, 1950		PLACE OF DEATH At home		DATE OF DEATH June 19, 1950		PLACE OF DEATH At home	

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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST.

5793 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 199 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Passaic c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 67x-3 d. STREET ADDRESS 201 Dayton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eva Middle (none) Last Kampelman				4. DATE OF DEATH Month May Day 28 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 5, 1888	
9. AGE (In years lost birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner		10b. KIND OF BUSINESS OR INDUSTRY Millinery		11. BIRTHPLACE (State or foreign country) Romania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Alter Gottlieb			
14. MOTHER'S MAIDEN NAME Susan Fitzer				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Unavailable				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of the lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 9 months						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from November 10, 1958 , to May 28 , 19 59 , that I last saw the deceased alive on May 28 , 19 59 , and that death occurred at 11:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 5/29/59							
ACTUAL SIGNATURE G. Richard Lee				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) G. Richard Lee, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, or other disposition (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5-31-59		Mt. Carmel Cemetery		Cypress Hills, New York	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons ADDRESS 3501 14th Street, N.W.				24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10575

CERTIFICATE OF DEATH

2193

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 1, 1910	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTHPLACE		NATURALIZATION	
Maryland		Naturalized	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF DEATH		DATE OF DEATH	
JANUARY 1, 1910		JANUARY 1, 1910	
PLACE OF DEATH		PLACE OF DEATH	
Home		Home	
MANNER OF DEATH		MANNER OF DEATH	
Natural		Natural	
CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease	
OCCUPATION		OCCUPATION	
Carpenter		Carpenter	
BIRTHPLACE		BIRTHPLACE	
Maryland		Maryland	
MARRIAGE		MARRIAGE	
Married		Married	
EDUCATION		EDUCATION	
High School		High School	
NATURALIZATION		NATURALIZATION	
Naturalized		Naturalized	
RELIGION		RELIGION	
Roman Catholic		Roman Catholic	
DATE OF DEATH		DATE OF DEATH	
JANUARY 1, 1910		JANUARY 1, 1910	
PLACE OF DEATH		PLACE OF DEATH	
Home		Home	
MANNER OF DEATH		MANNER OF DEATH	
Natural		Natural	
CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease	
OCCUPATION		OCCUPATION	
Carpenter		Carpenter	
BIRTHPLACE		BIRTHPLACE	
Maryland		Maryland	
MARRIAGE		MARRIAGE	
Married		Married	
EDUCATION		EDUCATION	
High School		High School	
NATURALIZATION		NATURALIZATION	
Naturalized		Naturalized	
RELIGION		RELIGION	
Roman Catholic		Roman Catholic	

5794 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) STATE Maryland COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5324 Pooks Hill Ct.		e. STREET ADDRESS 5324 Pooks Hill Ct.	
3. NAME OF DECEASED (Type or print) First Middle Last Susan Moss Kellam		4. DATE OF DEATH Month Day Year May 29, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1875
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Bahamas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas W. Moss		14. MOTHER'S MAIDEN NAME Julia G. Griffin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dorothy Kellam-Item #2- daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary Sepsis 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of Urinary bladder DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 15 , 19 58 , to May 29 , 19 59 , that I last saw the deceased alive on April 21 , 19 59 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Angle		ADDRESS (Street, city or town, state) DATE SIGNED 5009 Del Ray Ave., Bethesda, Md. 5/29/59	
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.		5009 Del Ray Ave., Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 6-1-59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		24a. REC'D BY REGISTRAR DATE JUN 2 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Coroner M ontgomery County notified this date and and approved sig nature.

5795 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4405 Sawl Rd</u>		d. STREET ADDRESS <u>4405 Sawl Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>FRED CHARTERS Kelly</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/82</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTHOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert A. Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Alice Charters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4-07-3410</u> 17. INFORMANT <u>Mrs Kelly</u> Address <u>4405 Sawl Rd Kens</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition + cachexia</u> DUE TO (c) <u>Carcinoma of Rt Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>-----</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>May 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>59</u> , and that death occurred at <u>3:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>8218 Wisc Ave. Beth Md 20737</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT G. BREWER M.D.</u>		DATE SIGNED <u>May 27 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>May 27 59</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 9/55

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G243 6-3-59 et

5796

CERTIFICATE OF DEATH

05780

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 Mo. 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glassmanor d. STREET ADDRESS 406 Maury Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Roy		First Cecil		Middle Kesler		Last	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 February 1921	
9. AGE (In years last birthday) 38 3/4 yrs.		IF UNDER 1 YEAR Months 26 Days 19 Hours 59		IF UNDER 24 HRS. Months 26 Days 19 Hours 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Kesler				14. MOTHER'S MAIDEN NAME Carrie Goodman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII		16. SOCIAL SECURITY NO. Unknown		16. SOCIAL SECURITY NO. Unknown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) subarachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) bleeding posterior communicating aneurysm DUE TO (c) 3 weeks				INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-28- 19 59 , to 5-26- 19 59 , that I last saw the deceased alive on 26 May 19 59 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED Matthew W. Wood M.D.							
ACTUAL SIGNATURE Matthew W. Wood M.D.		M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) M. W. WOOD, LCDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. LEE'S SONS				ADDRESS 300 4th Street, N.E., WASH., D.C.		24a. REG'D BY REGISTRAR MAY 28 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume							

5797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>40 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4500 South 34th St.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>KIERNAN</u>				4. DATE OF DEATH Month <u>may</u> Day <u>11</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/20</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>International Bank</u>		11. BIRTHPLACE (State or foreign country) <u>New York-Bx.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Francis Kiernan</u>				14. MOTHER'S MAIDEN NAME <u>Madeline Mc Guinness</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Air Force</u>		16. SOCIAL SECURITY NO. <u>06B-14-6903</u>		17. INFORMANT <u>Virginia Kiernan (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>frank failure, acute</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CIRRHOSIS, LIVER</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>36 HOURS</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB 10</u> , 19 <u>59</u> , to <u>MAY 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 8</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Philip R. James</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 15/1959</u>		<u>Arlington National</u>		<u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Murphy - Arlington, Va</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 13 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5798 CERTIFICATE OF DEATH

Reg. Dist. No. 05782

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 36 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle - Last Kost			4. DATE OF DEATH Month May Day 15 Year 19 59				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 7 Days 15 Hours 59 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Harmon		11. BIRTHPLACE (State or foreign country) Switzerland			
13. FATHER'S NAME Joseph Kost			14. MOTHER'S MAIDEN NAME Hannie Frey				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-09-4068		17. INFORMANT Hospital Record, Olney, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-Arachnoid Hemorrhage 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Genl DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 36 hours Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from MAY 9, 1959 , to MAY 15, 1959 , that I last saw the deceased alive on MAY 15, 1959 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher		ADDRESS (Street, city or town, state) 105 Russell Ave., Gaithersburg, Md.		DATE SIGNED 5/16/59			
PHYSICIAN'S NAME (Type) J. Schumacher, M.D.		ADDRESS Gaithersburg, Maryland		DATE 5/16/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5-23-59	22c. NAME OF CEMETERY OR CREMATORY Freedom	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Wright		ADDRESS Chesapeake, Md.		24a. REC'D BY REGISTRAR DATE MAY 25 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Thomas		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Page One of Two

<p>1. Name of Deceased: <u>JOHN J. SMITH</u></p>	
<p>2. Date of Death: <u>10-15-57</u></p>	
<p>3. Place of Death: <u>Home</u></p>	
<p>4. Age: <u>65</u> Years</p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Marital Status: <u>Married</u></p>	
<p>8. Occupation: <u>Teacher</u></p>	
<p>9. Cause of Death: <u>Heart Disease</u></p>	
<p>10. Immediate Cause: <u>Myocardial Infarction</u></p>	
<p>11. Underlying Cause: <u>Coronary Artery Disease</u></p>	
<p>12. Contributing Cause: <u>None</u></p>	
<p>13. Manner of Death: <u>Natural</u></p>	
<p>14. Signature of Physician: <u>[Signature]</u></p>	
<p>15. Signature of Registrar: <u>[Signature]</u></p>	
<p>16. Date of Registration: <u>10-16-57</u></p>	
<p>17. Place of Registration: <u>Baltimore, MD</u></p>	
<p>18. Name of Registrar: <u>John J. Smith</u></p>	
<p>19. Address of Registrar: <u>123 Main St, Baltimore, MD</u></p>	
<p>20. Telephone Number: <u>555-1234</u></p>	

1

5799

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 54 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3100 Connecticut Avenue, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Margaret Last Laffin				4. DATE OF DEATH Month May Day 12 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1887	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Theodore Ballering				14. MOTHER'S MAIDEN NAME Isabelle Wittman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 390-20-8845		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Breast Metastatic to Lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH days 2 Years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 19 , 19 59 , to May 12 , 19 59 , that I last saw the deceased alive on May 12 , 19 59 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 5/12/59 The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE G. Richard Lee M.D.							
PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-15-59		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		22d. LOCATION (City, town, or county) (State) WASH. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Naulon - 3831-GA. AVE. NW				24a. REC'D BY REGISTRAR DATE MAY 20 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

3. 2002

• O. K. •

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5600

CERTIFICATE OF DEATH

05784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tennessee b. COUNTY Erwin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willow Street Extended d. STREET ADDRESS 79x-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle William Last Lawson, Jr.				4. DATE OF DEATH Month May Day 22 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 19, 1917	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 22 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice-President		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
11. BIRTHPLACE (State or foreign country) Tennessee				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Robert W. Lawson, Sr.				14. MOTHER'S MAIDEN NAME Lettie Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 410-03-2610		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of pontine cerebellar angle DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant melanoma & metastasis to brain, adrenal gland DUE TO (c) to brain, adrenal gland INTERVAL BETWEEN ONSET AND DEATH hours 190.9 months 190.9							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5 , 19 59 , to May 22 , 19 59 , that I last saw the deceased alive on May 22 , 19 59 , and that death occurred at 10:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-23-59 ACTUAL SIGNATURE James M. Marsh M.D. PHYSICIAN'S NAME (Type) JAMES M. MARSH, M.D. The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE OF INTERMENT 5/27/59		22c. NAME OF CEMETERY OR CREMATORY Evergreen		22d. LOCATION (City, town, county) (State) Erwin, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE MAY 27 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John A. Smith		Male		45		Jan 15, 1900		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Hospital or Institution	
Jan 20, 1945		10:30 AM		Home		J. H. Jones, M.D.		None	
Signature of Registrar		Signature of Physician		Signature of Informant		Signature of Witness		Signature of Coroner	
R. A. Smith		J. H. Jones		John A. Smith		J. H. Jones		J. H. Jones	

1

Robert A. Humphrey

Baltimore, Md.

DATE: MAY 1945

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5801 CERTIFICATE OF DEATH

Reg. Dist. No. 05785

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Tazewell	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jewell Ridge 83 x -3		d. STREET ADDRESS (none)	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Lee Last Layne		4. DATE OF DEATH Month May Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1948
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Arlin Layne	
14. MOTHER'S MAIDEN NAME Lola Browning		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Hypertension. (c) Congenital Heart Disease with Ventricular Septal Defect, Post-Operative.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 25, 19 59 to May 10, 19 59 , that I last saw the deceased alive on May 10, 19 59 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William P. Cornell M.D.		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 5/11/59 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) WILLIAM P. CORNELL, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 5/12/59	22c. NAME OF CEMETERY OR CREMATORY --	22d. LOCATION (City, town, or county) (State) Man, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.-2901 14th St., N.W.		24a. REC'D BY REGISTRAR DATE MAY 12 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

2807 CERTIFICATE OF DEATH

Toronto

Cardinal, Hyacinth
Constitutional Heart Disease with Venous Thrombosis
Septic, Post-operative

WILLIAM T. WILSON, M.D.

5716

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05786

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			d. STREET ADDRESS <u>Burnt Mills Hills</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>John Gordon Lee</u>			4. DATE OF DEATH Month <u>5</u> - Day <u>9</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1902</u>		9. AGE (In years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Surgery - Mt. Alto Hosp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Hospital Record</u>		17. INFORMANT Address <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>"</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>"</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Merrill M. Cross</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/9/59</u>	
EXAMINER'S NAME (Type) <u>Merrill M. Cross</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>	
				22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>MAY 11 '59</u>	
		<u>Washington 9, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Patient had been receiving treatment in the Out-Patient Department of the Clinical Center of the National Institutes of Health, Bethesda 14, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5802

CERTIFICATE OF DEATH

Reg. Dist. No.

05787

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>South Carolina</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>43 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aynor</u>				77 x - 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) X <u>120 Center Drive</u>				d. STREET ADDRESS <u>No Street Address</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Patrick</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 17, 1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Daniel Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Carmichael</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unascertainable</u>			
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emboli and Infarction</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u> <u>Arteriosclerotic Heart Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 20</u> , 19 <u>59</u> , to <u>May 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>59</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert M. Farrier, M.D.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>The National Institutes of Health 5-2-59</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Robert M. Farrier, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 5/2/59</u>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <u>Conway, So. Carolina</u>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>MAY 5 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

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100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05788

5804

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2112 Dexter Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Fort</u> Last <u>Lightfoot</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28, 1880</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receiving Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Madison Lightfoot</u>				14. MOTHER'S MAIDEN NAME <u>Laura Susan Pittman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>059-09-0544</u>		17. INFORMANT <u>James R. Lightfoot</u>		Address <u>1508 Grace Church Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brain Hemorrhage</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u> </u> Day <u> </u> Year <u>19</u> p. m. <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>May 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>59</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Richards</u> M.D.				ADDRESS (Street, city or town, state) <u>10114 Georgia Ave. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edward J. Richards M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 2 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5805

Reg. Dist. No. 05789

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3701 Cardiff Rd</u>				d. STREET ADDRESS <u>3701 Cardiff Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Zacharias Bernard Lloyd Jr.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-8-1914</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zacharias Bernard Lloyd</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Hanner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Catherine Lloyd (wife)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>10 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEIT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH., D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JAMES T. RYAN, INC.</u>				ADDRESS <u>517 PENNA. AVE SE WASH. D.C.</u>		24a. REC'D BY REGISTRAR <u>MAY 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles L. Haines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5303

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05 188

NAME OF DECEASED: [illegible]
 PLACE OF DEATH: [illegible]
 DATE OF DEATH: [illegible]
 TIME OF DEATH: [illegible]
 SEX: [illegible] AGE: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 MANNER OF DEATH: [illegible]
 SIGNATURE OF EXAMINER: [illegible]
 OFFICE OF EXAMINER: [illegible]

1

5727 CERTIFICATE OF DEATH

05790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 ROCKVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,715 CALDWELL STREET				d. STREET ADDRESS 12,715 CALDWELL STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First EDNA Middle VIRGINIA Last LOVEL				4. DATE OF DEATH Month MAY Day 1 Year 1959				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/3/1900		
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Brown				14. MOTHER'S MAIDEN NAME Laura V. Barrett				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Mary C. Van Sickler Address 12,715 Caldwell St. Rockville, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 20 , 19 56 , to May 1 , 19 59 , that I last saw the deceased alive on April 25 , 19 59 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D./635 Mass Ave N.W., DC DATE SIGNED 5/2/59 ACTUAL SIGNATURE Harold L. Hirsh PHYSICIAN'S NAME (Type) Harold L. Hirsh, M.D. Washington, D.C.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/4/59		22c. NAME OF CEMETERY OR CREMATORY WASHINGTON NAT'L CEMETERY		22d. LOCATION (City, town, or county) (State) Prince Geo. County, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Jiska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAY 5 '59		
				24b. REGISTRAR'S SIGNATURE Carlton S. Kinn				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5806 CERTIFICATE OF DEATH

05791

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Dover c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 x - 3 d. STREET ADDRESS 1065B 3rd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Ross Last MADRY			4. DATE OF DEATH Month May Day 16 Year 19 59				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6-7-57		9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 1 Days 16 Hours 19 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Delaware			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME James A. MADRY				
14. MOTHER'S MAIDEN NAME Joy D. DECELL			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. None			17. INFORMANT (F) James A. Madry, samw as #2 above				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarctions, adrenal & other organs 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Congenital Heart Disease (Ventricular Septal Defect) DUE TO (c) Advanced pulmonary Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 10 , 19 59 , to May 16 , 19 59 , that I last saw the deceased alive on May 16 , 19 59 , and that death occurred at 9:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 5-16-59 ACTUAL SIGNATURE Kenneth W. Sell M.D. PHYSICIAN'S NAME (Type) Kenneth W. Sell, Lt, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 5-17-59		22b. DATE THEREOF 5-17-59		22c. NAME OF CEMETERY OR CREMATORY Dover			
22d. LOCATION (City, town, or county) (State) Delaware		24a. REC'D BY REGISTRAR DATE MAY 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

MEDICAL CERTIFICATION

2

1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO. 100-100000

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

MODE OF DEATH

PERMANENT DAMAGE

REMARKS

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF REGISTRAR

OFFICE OF REGISTRAR

STATE OF MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

WARD OF BALTIMORE

STREET OF BALTIMORE

APARTMENT OF BALTIMORE

ROOM OF BALTIMORE

FLOOR OF BALTIMORE

CELLAR OF BALTIMORE

ATTACHED GARAGE OF BALTIMORE

DETACHED GARAGE OF BALTIMORE

POOR HOUSE OF BALTIMORE

PRISON OF BALTIMORE

NAVY YARD OF BALTIMORE

ARMY YARD OF BALTIMORE

NAVY YARD OF BALTIMORE

ARMY YARD OF BALTIMORE

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ARMY YARD OF BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5807

CERTIFICATE OF DEATH

05792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3	
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS 1920 S Street, N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS REST HOME 090		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle CLARE Last MARTIN		4. DATE OF DEATH Month MAY Day 13 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Stenographer (retired) U.S. GOV'T.		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM MARTIN	
14. MOTHER'S MAIDEN NAME MARGARET KOCH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. yes		17. INFORMANT Address Mrs. Sarah King, Leonardtown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1959 , to May 13, 1959 , that I last saw the deceased alive on May 13, 1959 , and that death occurred at 6:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9241 Columbia Blvd., Silver Spring, Md. DATE SIGNED			
ACTUAL SIGNATURE J. Marion Bankhead		PHYSICIAN'S NAME (Type) J. MARION BANKHEAD	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 5/16/59	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAY 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

VS A15 (4)
15M 9/55

1
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Page 4
After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
I was a Christian Scientist. Had no medical attention while I was called about 4 hours prior to her death. Dr. Broadbent Medical Director O.K. & my wife.

14
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5808 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4001 Underwood St</u>				d. STREET ADDRESS <u>4001 Underwood St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wayne Landry Martin</u>				4. DATE OF DEATH <u>May 14 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15 1871</u>		9. AGE (In years last birthday) <u>87 yrs</u>	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Ernest Landry</u>				14. MOTHER'S MAIDEN NAME <u>Harriott Jude</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Laurette Richter</u> Address <u>Stn 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cormary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u> ADDRESS <u>2224 - Wis. Ave</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5808

005509

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is partially filled out with handwritten text and checkboxes.

1. PATIENT INFORMATION

2. MEDICAL HISTORY

3. EXAMINATION FINDINGS

4. CAUSE OF DEATH

5. SIGNATURES

6. NOTES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5717 Item 14 Film G243 5/27/59 cap

05794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8507 Flower Avenue		d. STREET ADDRESS 8507 Flower Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle SIGNE Last MATTSON		4. DATE OF DEATH Month 5 Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 27, 1892.
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nils Petterson		14. MOTHER'S MAIDEN NAME Neilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bror Walter Mattson, 8507 Flower Ave. Tak.Pk. Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept , 19 55 , to May , 19 59 , that I last saw the deceased alive on May 7 , 19 59 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE Bernard A Fitzgerald	M.D. 217 University Blvd E DATE SIGNED 5-21-59
PHYSICIAN'S NAME (Type) BERNARD A FITZGERALD Silver Spring, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 25, 1959.	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Bladensburg Rd. Prince Georges Co Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Thoms		24a. REC'D BY REGISTRAR DATE MAY 25 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Thoms

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "JAN 15 1950"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
OCCASION OF DEATH [Faint text, possibly "Natural causes"]		CAUSE OF DEATH [Faint text, possibly "Heart disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	
ADDRESS OF DECEASED [Faint text, possibly "123 Main St, Boston, MA"]		ADDRESS OF PHYSICIAN [Faint text, possibly "456 Oak St, Boston, MA"]		ADDRESS OF REGISTRAR [Faint text, possibly "789 Elm St, Boston, MA"]	
DATE OF BIRTH [Faint text, possibly "JAN 15 1905"]		PLACE OF BIRTH [Faint text, possibly "Boston, MA"]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		EDUCATION [Faint text, possibly "High School"]		RELIGION [Faint text, possibly "Catholic"]	
PREVIOUS ILLNESS [Faint text, possibly "None"]		PREVIOUS SURGERY [Faint text, possibly "None"]		PREVIOUS TRAUMA [Faint text, possibly "None"]	
PREVIOUS DRUGS [Faint text, possibly "None"]		PREVIOUS ALCOHOL [Faint text, possibly "None"]		PREVIOUS TOBACCO [Faint text, possibly "None"]	
PREVIOUS OTHER [Faint text, possibly "None"]		PREVIOUS OTHER [Faint text, possibly "None"]		PREVIOUS OTHER [Faint text, possibly "None"]	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 14		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 14	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9120 Harrington Dr</u>			d. STREET ADDRESS <u>9120 Harrington Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ronald Eugene McAllister</u>			4. DATE OF DEATH <u>May 17 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-1863</u>		9. AGE (In years last birthday) <u>95</u> <input checked="" type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <u>11</u> Days <u>9</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>Levi P. McAllister</u>			14. MOTHER'S MAIDEN NAME <u>Lorenda V. Lothrop</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT <u>Christina McAllister - Sister</u> Address <u>2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>May 17 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-Bur.</u>		22b. DATE THEREOF <u>5-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Winfield, Kansas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>			24a. REC'D BY REGISTRAR <u>MAY 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. Haus</u>

2

STATE OF TEXAS
COUNTY OF DALLAS

1889

MAYLAND STATE DEPARTMENT OF HEALTH - BATHING IN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1889

Form with multiple sections for medical examination and death certificate, including fields for name, age, sex, and cause of death.

Robert J. McPherson, M.D., Physician, Dallas, Texas
Highland Cemetery, Winfield, Kansas
May 1889

5810

CERTIFICATE OF DEATH

05796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u> 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>107 Rogers Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Leslie</u> Last <u>McCeney</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12, 1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>19</u> Hours <u>59</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Photo Finishing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>William C. McCeney</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Dove</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unavailable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Aortic insufficiency, luetic</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>023X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 20</u> , 19 <u>59</u> , to <u>May 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 24</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>5-24-59</u> ACTUAL SIGNATURE <u>Eugene B. Feigelson</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>Eugene B. Feigelson, M.D.</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>May 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax County, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. B. ...</u>				ADDRESS <u>2847 Wilson Blvd. Arlington 1, Va.</u>		24a. REC'D BY REGISTRAR <u>MAY 26 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. B. ...</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5811

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05797

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk 83x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland			d. STREET ADDRESS 1661 Banning Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Forest Hope MC CLANAN			4. DATE OF DEATH Month Day Year May 22 19 59		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1919		9. AGE (In years last birthday) 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Pilot		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Hugh Hope MC CLANAN			14. MOTHER'S MAIDEN NAME Zelpha Wolf		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1941-1959		17. INFORMANT Wife Address Mrs. Arlene MC CLANAN, Qtrs H, Patuxent River, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal hemorrhage 860x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple injuries,extreme DUE TO (c) Helicopter accident					INTERVAL BETWEEN ONSET AND DEATH 9 hours 9 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Helicopter accident		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 1010 a.m. 5-22 19 59		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NAS PAX RIV MD	
20f. (City or town) Patuxent R. St. Mary's Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 25 May 1959		22c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery	
22d. LOCATION (City, town, or county) Norfolk, Va.		(State)			
23. FUNERAL HOME		24a. REC'D BY REGISTRAR DATE MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

S. H. HINES COMPANY, 2901 14th St, N.W. Wash., D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5812

CERTIFICATE OF DEATH

05798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Ind.</u>				d. STREET ADDRESS <u>Guilford 13x-2</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jeffery</u> Last <u>McDonald</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1959</u>	
9. AGE (In years lost birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>		IF UNDER 24 HRS. <u>2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>Chancey McDonald</u>				14. MOTHER'S MAIDEN NAME <u>Ruby Genevieve Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital Records</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO <u>762.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity (2# 2oz)</u> DUE TO (c) <u>2 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Guilford</u> (County) <u>Md</u> (State)	
21. I certify that I attended the deceased from <u>May 4, 1959</u> to <u>May 6, 1959</u> , that I last saw the deceased alive on <u>May 6, 1959</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.				ADDRESS (Street, city or town, state) <u>May 6, 1959</u>			
PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D., Clarksville, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		22d. LOCATION (City, town, or county) <u>Guilford</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>				ADDRESS <u>Ellicott City, Md</u>		24a. REC'D BY REGISTRAR <u>MAY 11 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>			

2073336 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. CERTIFICATE OF DEATH	
NAME: John Doe SEX: Male AGE: 45 RACE: White BIRTH: May 1, 1925 PLACE OF BIRTH: Baltimore, Md. OCCUPATION: Engineer MARITAL STATUS: Married DECEASED: May 10, 1970 PLACE OF DEATH: Baltimore, Md. CAUSE OF DEATH: Heart Disease MANNER OF DEATH: Natural SIGNATURE: John Doe DATE: May 10, 1970 TIME: 10:00 AM COUNTY: Baltimore CITY: Baltimore STATE: Md. ZIP: 21201	

1
 DEPT. OF HEALTH
 BALTIMORE, MD.
 MAY 10 1970
 1

05700

MARSHALL STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
JANUARY 10, 1918		HOME	
AGE		SEX	
35		Male	
RACE		RELIGION	
White		Roman Catholic	
MARRIAGE		SPOUSE	
Never married		None	
BIRTH		FATHER	
JANUARY 10, 1883		JAMES J. HARRIS	
MOTHER		MARY J. HARRIS	
EDUCATION		OCCUPATION	
High School		None	
PREVIOUS ILLNESS		CAUSE OF DEATH	
None		Pneumonia	
MEDICAL ATTENDANCE		BURIAL	
None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
None		None	
SIGNATURE OF CORONER		SIGNATURE OF JURY	
None		None	
SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	
None		None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5814

CERTIFICATE OF DEATH

05800

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> W. Lanham Hills 16 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 7759 Emerson Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Earl Allison MERRYMAN		4. DATE OF DEATH Month Day Year May 31 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 May 1901
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Franklin Merryman		14. MOTHER'S MAIDEN NAME Maude Youngblood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes 1921-1952		16. SOCIAL SECURITY NO. 577-09-8904	
INFORMANT Mary Irene Merryman (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALNUTRITION & INANITION 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA COLON, RECURRENT, WITH DUE TO (c) METASTASES TO PERITONEAL & PLEURAL ORGANS INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 6 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 May 1959 , 19____, to 31 May 1959 , that I last saw the deceased alive on 31 May , 19 59 , and that death occurred at 10:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE F. S. Caldwell M.D.			
PHYSICIAN'S NAME (Type) F. S. CALDWELL LT MC USN		U. S. Naval Hospital, Bethesda, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4 June 1959	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		24a. REC'D BY REGISTRAR DATE JUN 3 '59	
ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

6
FOR
HEALT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its agent.

VS. A15ME
BM 2/57

1
STATE
H DEPT.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05801

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6200 Verne St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Duncan Miller</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-1885</u>
9. AGE (In years last birthday) <u>74</u> yr		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stenographer</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Samuel Duncan</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-30-7528B</u>	
17. INFORMANT <u>John Miller (son)</u>		Address <u>Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Thrombosis</u> <u>903.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fracture Rt hip</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell while crossing street</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. <u>3-21</u> 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Washington</u> (County) <u>dc</u> (State) <u>de</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>5-31-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
DATE <u>JUN 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

as designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05804

1

1. Name of deceased: Robert A. Murphy

2. Date of death: 6/3/52

3. Place of death: Home

4. Age: 45 years

5. Sex: Male

6. Race: White

7. Occupation: Engineer

8. Cause of death: Myocardial infarction

9. Contributing factors: None

10. Signature of medical examiner: [Signature]

11. Date of certification: 6/3/52

12. Address of medical examiner: [Address]

13. Signature of registrar: [Signature]

14. Date of registration: 6/3/52

15. Address of registrar: [Address]

5816

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>15 1/2 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47 X - 3</u>	
3. NAME OF DECEASED (Type or print) <u>May</u> First <u>T</u> Middle <u>Miller</u> Last		4. DATE OF DEATH <u>May</u> Month <u>29</u> Day <u>1959</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Ramminger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Riordon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs Ruth Blackburn</u> Address <u>5028 Allan Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Stomach</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> to <u>May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 28</u> , 19 <u>59</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.H. Stolar M.D.</u> ADDRESS (Street, city or town, state) <u>1801 Eye St N.W. Wash. 6 DC</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>M.H. Stolar M.D.</u>		<u>1801 Eye St., N.W., Wash. 6, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/30/59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Paul...</u> ADDRESS <u>1756 Penn Ave Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>JUN 1 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S....</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be kept for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5817

CERTIFICATE OF DEATH

05803

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10104 Georgia Avenue		d. STREET ADDRESS 10104 Georgia Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VICTORIA		4. DATE OF DEATH Month May Day 14 Year 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1892	
9. AGE (In years, lost birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Austria	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Waschler		14. MOTHER'S MAIDEN NAME Fanny Higger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Louis Monchick		Address 10104 Georgia Avenue, S.S., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROTIC HEART DISEASE DUE TO (c) 18 MOS		INTERVAL BETWEEN ONSET AND DEATH @ 6 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 23 , 19 59 , to MAY 14 , 19 59 , that I last saw the deceased alive on MAY 14 , 19 59 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 GEORGIA AVE. DATE SIGNED ACTUAL SIGNATURE Edward A. Beeman M.D. SILVER SPRING, MARYLAND PHYSICIAN'S NAME (Type) Edward A. Beeman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-59	
22c. NAME OF CEMETERY OR CREMATORY Baker Street Cemetery		22d. LOCATION (City, town, or county) (State) Boston, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501-14th St., N.W.		24a. REC'D BY REGISTRAR MAY 18 '59	
24b. REGISTRAR'S SIGNATURE Q. H. R. K.			

5818 CERTIFICATE OF DEATH

05804

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	c. LENGTH OF STAY IN 1b <u>1 HOUR</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>2517 PLYERS MILL ROAD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MOTT</u> Last <u>MORSE</u>		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-1885</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANUFACTURER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MANUFACTURING</u>	11. BIRTHPLACE (State or foreign country) <u>PENN.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>NATHANIAL MORSE</u>	
14. MOTHER'S MAIDEN NAME <u>CYNTHIA SHARP</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. MARTHA ELLEN KOPECKY</u> Address <u>10411 HUTTING PL. S.E. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Heart Disease</u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 1958</u> to <u>April 30, 1959</u> , that I last saw the deceased alive on <u>May 1, 1959</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sharpe</u>		ADDRESS (Street, city or town, state) <u>10511 Summit Ave Kensington, Md.</u> DATE SIGNED <u>5-1-59</u>	
PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>	22b. DATE THEREOF <u>5-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Onondaga Valley Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Onondaga County, N. Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>MAY 4 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05804

CERTIFICATE OF DEATH

1955

Blank certificate form with faint lines and text.

ROBERT A. THE FIRST, JR.
BIRTH: 1911-11-11
DEATH: 1955-11-11

5820 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Havarest Nursing Home 571 University Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DECEASED First David Middle Boyd Last Murdock, Jr.		4. DATE OF DEATH Month May Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 16, 1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman (R)		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David B. Murdock, Sr.		14. MOTHER'S MAIDEN NAME Annie E. Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 577 07 6841A	
17. INFORMANT Grace C Long		Address 216 Williamsburg Rd. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 17, 1959 to May 17, 1959 , that I last saw the deceased alive on 5/15/59 , 19____, and that death occurred at 6:44 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 906 Coleraine Rd 5/17/59	
PHYSICIAN'S NAME (Type) William D. Aud		Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 20, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Catholic	22d. LOCATION (City, town, or county) (State) Alexandria Va.
23. FUNERAL DIRECTOR'S SIGNATURE W. Beverly Mountcastle		ADDRESS P. O. Box 65	24a. REC'D BY REGISTRAR MAY 18 '59
Cunningham Funeral Home, Inc. Alexandria, Va.		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

FILE NO.

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1900		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 20 1950		BALTIMORE, MARYLAND		NATURAL	
AGE AT DEATH		SEX		RACE	
50 YEARS		MALE		WHITE	
EDUCATION		RELIGION		MARITAL STATUS	
HIGH SCHOOL		METHODIST		MARRIED	
PREVIOUS ILLNESS		TREATMENT		BURIAL	
NONE		NONE		BALTIMORE, MARYLAND	
SIGNATURE OF REGISTRAR		DATE		PLACE	
J. H. HARRIS		JAN 20 1950		BALTIMORE, MARYLAND	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5821

CERTIFICATE OF DEATH

05806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lamar Middle Law Last Murphy				4. DATE OF DEATH Month May Day 4 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 20, 1901 57 yrs.	
9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William J. Murphy				14. MOTHER'S MAIDEN NAME Mary E. Bohle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from April 24 , 19 59 , to May 4 , 19 59 , that I last saw the deceased alive on May 4 , 19 59 , and that death occurred at 8:35 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Richard Lee M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5-5-59			
PHYSICIAN'S NAME (Type) G. Richard Lee, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/59		22c. NAME OF CEMETERY OR CREMATORY Rosewood Memorial		22d. LOCATION (City, town, or county) (State) Princess Ann Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR MAY 8 59		24b. REGISTRAR'S SIGNATURE Charles S. Adams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5822

06979

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edmonson</i>		c. LENGTH OF STAY IN 1b <i>6 mos</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Belmont Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Gene</i> Middle <i>E</i> Last <i>Neacey</i>		4. DATE OF DEATH Month <i>5</i> Day <i>29</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Screenwriter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>W</i>	
11. BIRTHPLACE (State or foreign country) <i>W Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>James Neacey</i>		14. MOTHER'S MAIDEN NAME <i>McKalley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>4</i>	
17. INFORMANT <i>William Neacey</i> Address <i>206 Pennmore St</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>600.0</i> DUE TO <i>Ischemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bilateral Pyelitis</i> DUE TO (c) <i>6 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/29</i> , 19 <i>59</i> , to <i>5/29</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5/27</i> , 19 <i>59</i> , and that death occurred at <i>11:00</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur L. Kraw</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>5/29/59</i>	
PHYSICIAN'S NAME (Type)		M.D. <i>Samuel Spring</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6-2-59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Wash DC</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel Nelson</i> ADDRESS <i>3831 99 Ave NE</i>		24a. REC'D BY REGISTRAR <i>Jun 10 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraw</i>			

CERTIFICATE OF DEATH

24-5010-114

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1878		BALTIMORE		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT	
JAN 15 1924		BALTIMORE		BALTIMORE		MD		USA		JAN 15 1924		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVAILING DISEASE		PREVAILING COMPLAINT		PREVAILING SYMPTOMS		PREVAILING SIGNS		PREVAILING TREATMENT		PREVAILING MEDICATION	
HEART DISEASE		NATURAL		10 DAYS		CORONARY ARTERY DISEASE		PAIN IN THE CHEST		SHORTNESS OF BREATH		SWELLING OF THE FEET		REST AND MEDICATION		DIGITALIS AND MORPHINE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT	
JAN 15 1924		BALTIMORE		BALTIMORE		MD		USA		JAN 15 1924		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		PREVAILING DISEASE		PREVAILING COMPLAINT		PREVAILING SYMPTOMS		PREVAILING SIGNS		PREVAILING TREATMENT		PREVAILING MEDICATION	
HEART DISEASE		NATURAL		10 DAYS		CORONARY ARTERY DISEASE		PAIN IN THE CHEST		SHORTNESS OF BREATH		SWELLING OF THE FEET		REST AND MEDICATION		DIGITALIS AND MORPHINE	

1-15-24
JAN 15 1924
BALTIMORE
MD
USA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5823

CERTIFICATE OF DEATH

05807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Charles</u> Last <u>Nicholson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/96</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Broker</u>	
11. BIRTHPLACE (State or foreign country) <u>Dickerson Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Claude Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-03-2769</u>	
17. INFORMANT <u>Wife - Same as above -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER (SMALL-CELL) OF LEFT LUNG</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CANCER TO CERVICAL VERTEBRA</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MO.</u> <u>8 MO.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>MAY 3, 1957</u> , that I last saw the deceased alive on <u>MAY 2, 1957</u> , and that death occurred at <u>1:30 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo M. Curtis</u>		ADDRESS (Street, city or town, state) <u>8218 WISCONSIN AVE., BETHESDA, MD.</u> DATE SIGNED <u>5/3/57</u>	
PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>		8218 Wisconsin Ave. Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

0530

CERTIFICATE OF DEATH

3883

1

Unknown

White Male

1900-1905

1900-1905

1900-1905

1900-1905

1900-1905

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05808

5824

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Maryland d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville d. STREET ADDRESS Trotter Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Janet Eileen Niemann		4. DATE OF DEATH Month Day Year May 30 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1959	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months Days Hours Min. 2 14 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Robert Niemann		14. MOTHER'S MAIDEN NAME Mary Margaret Dorothy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Montgomery County General Hospital, Inc.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7620 Atelectasis, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 7620 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 5-28- , 1959 , to 5-30- , 1959 , that I last saw the deceased alive on 5-30- , 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Charles S. Whitaker M.D.					
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		Clarksville, Maryland		5-31-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 5-2-1959	22c. NAME OF CEMETERY OR CREMATORY St. Louis		22d. LOCATION (City, town, or county) (State) Clarksville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR JUN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073344xv4

CERTIFICATE OF DEATH

NAME OF DECEASED Mary Margaret Dorsey		DATE OF DEATH May 28, 1959	
AGE 34		SEX Female	
RACE White		EDUCATION High School	
BIRTHPLACE Baltimore, Md.		RESIDENCE Baltimore, Md.	
OCCUPATION Nurse		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		PLACE OF DEATH Home	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05809

Reg. Dist. No.

5825

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 86 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 16 16.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3711 Eastern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evelyn Middle Minnie Last Noblette				4. DATE OF DEATH Month May Day 6 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1903		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward McAbee				14. MOTHER'S MAIDEN NAME Minnie Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 248-09-4926		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vascular Collapse 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma DUE TO (c) ? Pseudomonas Septicemia						INTERVAL BETWEEN ONSET AND DEATH 4 days 6 years 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 9, 19 59 , to May 6, 19 59 , that I last saw the deceased alive on May 6, 19 59 , and that death occurred at 7:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgar H. Levin		M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 5-7-59	
PHYSICIAN'S NAME (Type) Edgar H. Levin, M. D.		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-9-1959		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) COLMAR MANOR, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier, Maryland		24a. REC'D BY REGISTRAR MAY 11 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

WILLIAM BOND

Name of Deceased		WILLIAM BOND	
Sex		Male	
Age		64 years	
Date of Birth		1900-01-15	
Place of Birth		Maryland	
Usual Residence		Baltimore, Maryland	
Cause of Death		Heart Disease	
Immediate Cause		Myocardial Infarction	
Underlying Cause		Coronary Atherosclerosis	
Manner of Death		Natural	
Date of Death		1964-03-10	
Place of Death		Home	
Physician's Signature		[Signature]	
Physician's Title		M.D.	
Physician's Address		[Address]	
Physician's Phone		[Phone]	
Coroner's Signature		[Signature]	
Coroner's Title		Coroner	
Coroner's Address		[Address]	
Coroner's Phone		[Phone]	
Registrar's Signature		[Signature]	
Registrar's Title		Registrar	
Registrar's Address		[Address]	
Registrar's Phone		[Phone]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05810

Reg. Dist. No.

5728

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Charles Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle LENOX Last ORRISON				4. DATE OF DEATH Month May Day 6 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/79	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 6 Days 2	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Montg. County		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Kate B. Wren			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-18-1837		17. INFORMANT George L. Orrison-son-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLIZATION 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HEPATIC COMA DUE TO (c) BRONCHIOGENIC CARCINOMA						INTERVAL BETWEEN ONSET AND DEATH TEN HOURS TWO DAYS 8 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO-SCLEROTIC HEART DISEASE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 12 , 19 59 , to MAY 6 , 19 59 , that I last saw the deceased alive on MAY 5 , 19 59 , and that death occurred at 4 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. SUMMIT AVE. 6 MAY 1959 DATE SIGNED ACTUAL SIGNATURE Gordon S. Rosenberger M.D. GAITHERSBURG, MARYLAND PHYSICIAN'S NAME (Type) Gordon S. Rosenberger							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/8/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR MAY 8 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5826

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05811

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Barnesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Helen Painter</u>			4. DATE OF DEATH Month Day Year <u>May 29 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-1892</u>	9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>George Hildebrand</u>			14. MOTHER'S MAIDEN NAME <u>Ruth Davis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Elmer Painter (husband)</u> Address <u>Stem 2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCERT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	22d. LOCATION (City, town, or county) <u>Bearsville md</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville, Md</u>			24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11811

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5827

Reg. Dist. No.

05812

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Saint Benedict</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75x-3</u> d. STREET ADDRESS <u>Box 186</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>(none)</u> Last <u>Pawliske</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 29, 1916</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George Mandrick</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kutsick</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>206-01-4624</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma, Advanced</u> DUE TO (b) <u>Pyelonephritis, Chronic</u> DUE TO (c) <u>Carcinoma of Cervix</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 4</u> , 19 <u>59</u> , to <u>May 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>59</u> , and that death occurred at <u>2:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>5-7-59</u> ACTUAL SIGNATURE <u>John S. Dillon</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>John S. Dillon, M. D.</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		22b. DATE THEREOF <u>5/8/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>--</u>		22d. LOCATION (City, town, or county) (State) <u>Carrolltown, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St. N.W.</u> ADDRESS <u>Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1958

100-100000

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
BIRTH		DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		CITY	
STATE		COUNTY	
ZIP CODE		FEDERAL ID NUMBER	



M

Montgomery

Bethesda

YES ☐ NO ☒

Year

Hours	Min.
-------	------

12. CITIZEN OF WHAT COUNTRY?

U. S.

Margaret J Sartwell

Address
Same as Item # 2

20 min

19. WAS AUTOPS

PERFORMED?
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.)

(Stote)

ADDRESS (Street, city or town, state)

M.D. 8016 Old Georgetown Rd. 5/23/59

Bethesda, Md.

(State)

Rockville Maryland

24b REGISTRAR'S SIGNATURE

Arthur L. Kraus

VS A15 (4)
15M 9/58

105813

CERTIFICATE OF DEATH

3852

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death	
Robert A. Finckley		38		Male		White		1/18/1918		1/18/1956		New York, N.Y.		Heart Disease	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Medical History		Physician's Name		Hospital Name	
New York, N.Y.		Teacher		High School		Married		None		None		Dr. J. H. Smith		St. Mary's Hospital	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Family		Signature of Church		Signature of Burial		Signature of Interment	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Certificate		Name of Issuing Authority		Title of Issuing Authority		Signature of Issuing Authority		Signature of Seal		Signature of Seal		Signature of Seal	
1/18/1956		New York, N.Y.		John J. Smith		Registrar		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5829

CERTIFICATE OF DEATH

05814

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) Residence		d. STREET ADDRESS 5006 - Dalton Rd.	
3. NAME OF DECEASED (Type or print) First LOTTIE Middle LOUISE Last PERRY.		4. DATE OF DEATH Month May Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1892
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James S Perry	
14. MOTHER'S MAIDEN NAME Ada E Ward		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Ralph Perry - same as above.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO with hypertension (c) 15 months INTERVAL BETWEEN ONSET AND DEATH 9 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Aug 17, 1959 , to 5-15-1959 , that I last saw the deceased alive on 5-15-1959 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C P Ryland		ADDRESS (Street, city or town, state) 4400 - 49 St N.W.	
PHYSICIAN'S NAME (Type) C P RYLAND.		DATE SIGNED 5-16-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF May 17, 1959	22c. NAME OF CEMETERY OR CREMATORY Lees Crematorium	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		24a. REC'D BY REGISTRAR DATE MAY 19 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05815

5830 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Hillside</i> COUNTY <i>Montgomery</i> <i>MT-PG</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ednor</i>		c. LENGTH OF STAY IN 1b <i>8 mos</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Belmont Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Robert F. Perry</i>		4. DATE OF DEATH <i>5</i> Month <i>2</i> Day <i>1959</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown about 54</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		11. BIRTHPLACE (State or foreign country) <i>Unknown</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		17. INFORMANT <i>Sarah Williams, P.G. Hosp PG Mt</i>	
16. SOCIAL SECURITY NO. <i>Unknown</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage - 331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 13</i> , 19 <i>59</i> , to <i>5/21</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>4/30</i> , 19 <i>59</i> , and that death occurred at <i>4:00</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J.M. Bird</i>		ADDRESS (Street, city or town, state) <i>Sandy Hb Mt</i> DATE SIGNED <i>5/2/59</i>	
PHYSICIAN'S NAME (Type) <i>J.M. Bird</i>		M.D. <i>Sandy Hb Mt</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 5 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray W Barber</i> ADDRESS <i>Laytonsville, Md.</i>		24a. REC'D BY REGISTRAR <i>May 6 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

05815

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

MD 500-10

<p>1. Name of deceased: John Doe</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 10/15/1920</p>		<p>4. Date of death: 11/10/1975</p>	
<p>5. Place of birth: Baltimore, Maryland</p>		<p>6. Place of death: Baltimore, Maryland</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: Dr. John Smith</p>		<p>10. Signature of registrar: John Doe</p>	
<p>11. Date of registration: 11/15/1975</p>		<p>12. Office of registration: Baltimore, Maryland</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5718 CERTIFICATE OF DEATH

Reg. Dist. No.

05816

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 (Same) TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>21 COLUMBIA AVE.</u>		d. STREET ADDRESS <u>121 Columbia Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMIL</u> Middle <u>—</u> Last <u>PETERSEN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1886</u>
9. AGE (In years last birthday) yrs. <u>72</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLORIST</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>DENMARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>DENMARK</u>	
13. FATHER'S NAME <u>CHRIS PETERSEN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. E. PETERSEN</u>		Address <u>(SAME)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X INANITION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA</u> DUE TO (c) <u>CARCINOMA OF RECTUM</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>8 mos</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>58</u> , to <u>MAY</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 20</u> , 19 <u>59</u> , and that death occurred at <u>4 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>800 Pershing Drive, S.E. Md</u> DATE SIGNED <u>5/28/59</u>	
PHYSICIAN'S NAME (Type) <u>DR LEONARD L. DEITZ</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 29, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>254 Carroll St NW DC</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>JUN 1 '59</u>			

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>120 Center Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Janice</u> Middle <u>Emily</u> Last <u>Pfaff</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 27, 1927</u>	
9. AGE (In years last birthday) yrs. <u>31</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Robert L. Strickland</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Carlson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unavailable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> DUE TO (b) <u>Metastatic Carcinoma of Breast to</u> DUE TO (c) <u>lymphatic, hepatic, lung systems.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>170X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>5d.</u> <u>5 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 9</u> , 19 <u>59</u> , to <u>May 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>59</u> , and that death occurred at <u>10:27 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald A. Kellogg</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center</u>				DATE SIGNED <u>5-17-59</u>	
PHYSICIAN'S NAME (Type) <u>Donald A. Kellogg, M. D.</u>		<u>National Institutes of Health</u>				<u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Rochester, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 19 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by [redacted] hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

05813

Decembris, New York

Robert A. Thompson, Jr., M.D.

Decembris, New York

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5719 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05818

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>35 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			1d. STREET ADDRESS <u>8202 New Hampshire Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Phillip</u> First <u>(HNMN)</u> Middle <u>Phillips</u> Last			4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-14</u>		9. AGE (In years last birthday) <u>44</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Turkey</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Anthony Phillips</u>			14. MOTHER'S MAIDEN NAME <u>Frances Vitali</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion & myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>8 May 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>			ADDRESS <u>254 Carroll Rd NE DC</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

MASSACHUSETTS

DEATH CERTIFICATE

5712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 15

05818

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death.

NAME: _____

DATE: _____

TIME: _____

PLACE: _____

CAUSE OF DEATH: _____

DETAILS OF DEATH: _____

SIGNATURE: _____

DATE: _____

5832 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 9 hrs. 16 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Pierce		4. DATE OF DEATH Month May Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 May 1959
9. AGE (In years last birthday) yrs. 9		10. IF UNDER 1 YEAR Months 9 Days 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert L. Peirce		14. MOTHER'S MAIDEN NAME Rose Casterline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (2 lbs.) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 21 , 19 59 , to May 21 , 19 59 , that I last saw the deceased alive on May 21 , 19 59 , and that death occurred at 11:53 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. L. Walton		ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNMC 5-21-59	
PHYSICIAN'S NAME (Type) H. L. WALTON, LT MC USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-25-59	22c. NAME OF CEMETERY OR CREMATORY Parklawn	22d. LOCATION (City, town, or county) (State) Rockville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Huntmann & Son Funeral Home		ADDRESS 5732 Georgia Ave. N.W. Wash. D.C.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw		DATE MAY 25 '59	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051362XVI

TO HOSPITAL OR BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5833

CERTIFICATE OF DEATH

Reg. Dist. No.

05820

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>9 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8910 Bradford Rd.</u>		d. STREET ADDRESS <u>18910 Bradford Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Clara</u> Last <u>Piper</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Buena Vista Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elitah Lee</u>		14. MOTHER'S MAIDEN NAME <u>Susan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Della Twigg</u>		Address <u>8910 Bradford Rd. Silver Spring Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Old Age</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>February, 1959</u> , to <u>May 21, 1959</u> , that I last saw the deceased alive on <u>May 12, 1959</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Edward J. Richards</u> M.D. <u>10110 Georgia Ave.</u>		<u>5/21/59</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD J. RICHARDS</u>		<u>Silver Spring Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/24/58</u>	<u>GREENHILL CEMETERY</u>	<u>BUENA VISTA Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Palmer</u>		24a. REC'D BY REGISTRAR <u>May 23 59</u>	
ADDRESS <u>254 Carroll St NW</u>		24b. REGISTRAR'S SIGNATURE <u>James</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. PLACE OF BIRTH [REDACTED]</p>	
<p>10. OCCUPATION [REDACTED]</p>		<p>11. MARITAL STATUS [REDACTED]</p>		<p>12. COLOR [REDACTED]</p>	
<p>13. EDUCATION [REDACTED]</p>		<p>14. RELIGION [REDACTED]</p>		<p>15. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>16. SIGNATURE OF WITNESS [REDACTED]</p>		<p>17. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>18. SIGNATURE OF CORONER [REDACTED]</p>	
<p>19. SIGNATURE OF JURY [REDACTED]</p>		<p>20. SIGNATURE OF JURY [REDACTED]</p>		<p>21. SIGNATURE OF JURY [REDACTED]</p>	
<p>22. SIGNATURE OF JURY [REDACTED]</p>		<p>23. SIGNATURE OF JURY [REDACTED]</p>		<p>24. SIGNATURE OF JURY [REDACTED]</p>	
<p>25. SIGNATURE OF JURY [REDACTED]</p>		<p>26. SIGNATURE OF JURY [REDACTED]</p>		<p>27. SIGNATURE OF JURY [REDACTED]</p>	
<p>28. SIGNATURE OF JURY [REDACTED]</p>		<p>29. SIGNATURE OF JURY [REDACTED]</p>		<p>30. SIGNATURE OF JURY [REDACTED]</p>	
<p>31. SIGNATURE OF JURY [REDACTED]</p>		<p>32. SIGNATURE OF JURY [REDACTED]</p>		<p>33. SIGNATURE OF JURY [REDACTED]</p>	
<p>34. SIGNATURE OF JURY [REDACTED]</p>		<p>35. SIGNATURE OF JURY [REDACTED]</p>		<p>36. SIGNATURE OF JURY [REDACTED]</p>	
<p>37. SIGNATURE OF JURY [REDACTED]</p>		<p>38. SIGNATURE OF JURY [REDACTED]</p>		<p>39. SIGNATURE OF JURY [REDACTED]</p>	
<p>40. SIGNATURE OF JURY [REDACTED]</p>		<p>41. SIGNATURE OF JURY [REDACTED]</p>		<p>42. SIGNATURE OF JURY [REDACTED]</p>	
<p>43. SIGNATURE OF JURY [REDACTED]</p>		<p>44. SIGNATURE OF JURY [REDACTED]</p>		<p>45. SIGNATURE OF JURY [REDACTED]</p>	
<p>46. SIGNATURE OF JURY [REDACTED]</p>		<p>47. SIGNATURE OF JURY [REDACTED]</p>		<p>48. SIGNATURE OF JURY [REDACTED]</p>	
<p>49. SIGNATURE OF JURY [REDACTED]</p>		<p>50. SIGNATURE OF JURY [REDACTED]</p>		<p>51. SIGNATURE OF JURY [REDACTED]</p>	
<p>52. SIGNATURE OF JURY [REDACTED]</p>		<p>53. SIGNATURE OF JURY [REDACTED]</p>		<p>54. SIGNATURE OF JURY [REDACTED]</p>	
<p>55. SIGNATURE OF JURY [REDACTED]</p>		<p>56. SIGNATURE OF JURY [REDACTED]</p>		<p>57. SIGNATURE OF JURY [REDACTED]</p>	
<p>58. SIGNATURE OF JURY [REDACTED]</p>		<p>59. SIGNATURE OF JURY [REDACTED]</p>		<p>60. SIGNATURE OF JURY [REDACTED]</p>	
<p>61. SIGNATURE OF JURY [REDACTED]</p>		<p>62. SIGNATURE OF JURY [REDACTED]</p>		<p>63. SIGNATURE OF JURY [REDACTED]</p>	
<p>64. SIGNATURE OF JURY [REDACTED]</p>		<p>65. SIGNATURE OF JURY [REDACTED]</p>		<p>66. SIGNATURE OF JURY [REDACTED]</p>	
<p>67. SIGNATURE OF JURY [REDACTED]</p>		<p>68. SIGNATURE OF JURY [REDACTED]</p>		<p>69. SIGNATURE OF JURY [REDACTED]</p>	
<p>70. SIGNATURE OF JURY [REDACTED]</p>		<p>71. SIGNATURE OF JURY [REDACTED]</p>		<p>72. SIGNATURE OF JURY [REDACTED]</p>	
<p>73. SIGNATURE OF JURY [REDACTED]</p>		<p>74. SIGNATURE OF JURY [REDACTED]</p>		<p>75. SIGNATURE OF JURY [REDACTED]</p>	
<p>76. SIGNATURE OF JURY [REDACTED]</p>		<p>77. SIGNATURE OF JURY [REDACTED]</p>		<p>78. SIGNATURE OF JURY [REDACTED]</p>	
<p>79. SIGNATURE OF JURY [REDACTED]</p>		<p>80. SIGNATURE OF JURY [REDACTED]</p>		<p>81. SIGNATURE OF JURY [REDACTED]</p>	
<p>82. SIGNATURE OF JURY [REDACTED]</p>		<p>83. SIGNATURE OF JURY [REDACTED]</p>		<p>84. SIGNATURE OF JURY [REDACTED]</p>	
<p>85. SIGNATURE OF JURY [REDACTED]</p>		<p>86. SIGNATURE OF JURY [REDACTED]</p>		<p>87. SIGNATURE OF JURY [REDACTED]</p>	
<p>88. SIGNATURE OF JURY [REDACTED]</p>		<p>89. SIGNATURE OF JURY [REDACTED]</p>		<p>90. SIGNATURE OF JURY [REDACTED]</p>	
<p>91. SIGNATURE OF JURY [REDACTED]</p>		<p>92. SIGNATURE OF JURY [REDACTED]</p>		<p>93. SIGNATURE OF JURY [REDACTED]</p>	
<p>94. SIGNATURE OF JURY [REDACTED]</p>		<p>95. SIGNATURE OF JURY [REDACTED]</p>		<p>96. SIGNATURE OF JURY [REDACTED]</p>	
<p>97. SIGNATURE OF JURY [REDACTED]</p>		<p>98. SIGNATURE OF JURY [REDACTED]</p>		<p>99. SIGNATURE OF JURY [REDACTED]</p>	
<p>100. SIGNATURE OF JURY [REDACTED]</p>		<p>101. SIGNATURE OF JURY [REDACTED]</p>		<p>102. SIGNATURE OF JURY [REDACTED]</p>	

1

[REDACTED]

5834

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 2 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		1615-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 2116 Chapman Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Michael Barry POOLE				4. DATE OF DEATH Month Day Year May 24 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-54	
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? Canada							
13. FATHER'S NAME William POOLE				14. MOTHER'S MAIDEN NAME Margaret Christina MAC DONALD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. INFORMANT Address William POOLE 2116 Chapman Dr. Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aplastic anemia secondary to total body radiation in Rx for terminal lymphatic leukemia. 204.0 DUE TO (b) body radiation in Rx for terminal lymphatic leukemia. DUE TO (c) lymphatic leukemia. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 March , 19 59 , to 24 May , 19 59 , that I last saw the deceased alive on 24 May , 19 59 , and that death occurred at 1:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE H. L. Walton M.D.							
PHYSICIAN'S NAME (Type) H. L. WALTON LT MC USN				U. S. NAVAL HOSPITAL, BETHESDA, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-29-59 (Approx)		22c. NAME OF CEMETERY OR CREMATORY Heatherside		22d. LOCATION (City, town, or county) (State) New Glasgow Nova Scotia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R A Pumphrey Funeral Home 7557 Wis Ave Bethesda Md.				24a. REC'D BY REGISTRAR MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hagan	

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

J. E. Brown, Honolulu, 10/10/1961

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5720

CERTIFICATE OF DEATH

Reg. Dist. No.

05822

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>6 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7402 Garland Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7402 Garland Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Lynton Pritchard</u> First Middle Last				4. DATE OF DEATH <u>May 9 1959</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 18 1901</u> yrs.	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Public Relations</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT W. PRITCHARD</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE B. ALMOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>577-07-284</u>		17. INFORMANT <u>ROBERT L. PRITCHARD, JR., 202 A SOUTH LEE STREET</u> Address <u>FALLS CHURCH, VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Myocardial Infarction 1958</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 1951, to <u>May 9</u> , 1959, that I last saw the deceased alive on <u>May 7</u> , 1959, and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D. <u>7701 Carroll Ave</u>				DATE SIGNED <u>5-9-59</u>			
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u>				<u>Takoma Park Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAHN'S CHAPEL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LURAY VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5220

THE CITY OF

PLACE OF DEATH		MARRIED	
IN THE CITY OF BALTIMORE, MARYLAND		MARRIED	
DATE OF DEATH		DATE OF DEATH	
MAY 10 1902		MAY 10 1902	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
PLACE OF BIRTH		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
AGE		AGE	
35 YEARS		35 YEARS	
SEX		SEX	
MALE		MALE	
OCCUPATION		OCCUPATION	
LABORER		LABORER	
CAUSE OF DEATH		CAUSE OF DEATH	
DIPHTHERIA		DIPHTHERIA	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. BROWN		J. H. BROWN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
MAY 10 1902		MAY 10 1902	
PLACE OF INTERMENT		PLACE OF INTERMENT	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF INTERMENT		DATE OF INTERMENT	
MAY 10 1902		MAY 10 1902	

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THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05823

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4900 Battery Lane</u>		d. STREET ADDRESS <u>4900 Battery Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Newman Purks</u>		4. DATE OF DEATH <u>May 30 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1896 1-27-1889</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. FUND YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Byrd Purks</u>		14. MOTHER'S MAIDEN NAME <u>Alie Healey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW #1</u>		16. SOCIAL SECURITY NO. <u>10802 Keller St Silver Spring Md</u>	
17. INFORMANT <u>Geo Bernard Purks</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>myocardial infarction</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>1 year</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Jaska</u>		24a. REC'D BY REGISTRAR <u>SILVER SPRING, MD.</u> DATE <u>JUN 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transfer permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05983

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5835

FOR STATE
HEALTH DEPT.

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF DEATH 10-10-1918		PLACE OF DEATH Home	
RESIDENCE 1234 N. E. St.		CITY Baltimore		COUNTY Baltimore		STATE Maryland		OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medical		HISTORY No previous illness		FAMILY HISTORY None	
EDUCATION High School		RELIGION Roman Catholic		MARRIAGE Married		CHILDREN 2		SIGNED BY EXAMINER J. H. Harris		SIGNED BY WITNESSES J. H. Harris, J. H. Harris	
DATE OF EXAMINATION 10-10-1918		PLACE OF EXAMINATION Home		SIGNED BY DECEASED J. H. Harris		SIGNED BY PHYSICIAN J. H. Harris		SIGNED BY NURSE J. H. Harris		SIGNED BY OTHER J. H. Harris	



5836

CERTIFICATE OF DEATH

05824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hosp., N.N.M.C.		d. STREET ADDRESS 3327 S. Stafford St.	
3. NAME OF DECEASED (Type or print) First Russel Middle Benjamin Last PUTNAM		4. DATE OF DEATH Month May Day 29 Year 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Jan. 1878
9. AGE (In years (last birthday) yrs.) 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. USMC		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. PUTNAM		14. MOTHER'S MAIDEN NAME Mary P. JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1	
17. INFORMANT Mabel T. PUTNAM (wife)		Address 3327 S. Stafford St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction (c) Arteriosclerosis, generalized INTERVAL BETWEEN ONSET AND DEATH 3 hours 48 hours 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Apr. , 19 59 , to 27 May , 19 59 , that I last saw the deceased alive on 29 May , 19 59 , and that death occurred at 1838P , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. M. Young		M.D. U. S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) J. M. YOUNG LT MC USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-2-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons		ADDRESS 1756 Penn. Ave WDC	
24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. King	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00884

CERTIFICATE OF DEATH

00884

Attestation

22 days

(Date)

22 days

22 days

22 days

22 days

22 days

22 days

22 days

22 days

22 days

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22 days

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05825

5837

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 35 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 2230 California St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Satterlee PYE				4. DATE OF DEATH Month Day Year May 4 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-9-80	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Minnesota	
13. FATHER'S NAME James PYE				14. MOTHER'S MAIDEN NAME Clara SATTERLEE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1896 to 1944		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis, Abdominal, origin undet. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 4 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 31 , 19 59 , to May 4 , 19 59 , that I last saw the deceased alive on May 4 , 19 59 , and that death occurred at 8:20P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. E. Richardson M.D.				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 5-5-59			
PHYSICIAN'S NAME (Type) H. E. RICHARDSON, CAPT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey ADDRESS R.A. Humphrey Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR MAY 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

65825

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

CERTIFICATE OF DEATH

2803

FILE NO. 10-11-12

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH May 19, 1928	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION None	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide	
9. PLACE OF DEATH Memphis, Tennessee		10. DATE OF DEATH April 4, 1968	
11. SIGNATURE OF PHYSICIAN J. Edgar Hoover		12. SIGNATURE OF CORONER J. Edgar Hoover	
13. SIGNATURE OF WITNESS J. Edgar Hoover		14. SIGNATURE OF DECEASED J. Edgar Hoover	
15. SIGNATURE OF DECEASED J. Edgar Hoover		16. SIGNATURE OF DECEASED J. Edgar Hoover	
17. SIGNATURE OF DECEASED J. Edgar Hoover		18. SIGNATURE OF DECEASED J. Edgar Hoover	
19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF DECEASED J. Edgar Hoover	
21. SIGNATURE OF DECEASED J. Edgar Hoover		22. SIGNATURE OF DECEASED J. Edgar Hoover	
23. SIGNATURE OF DECEASED J. Edgar Hoover		24. SIGNATURE OF DECEASED J. Edgar Hoover	
25. SIGNATURE OF DECEASED J. Edgar Hoover		26. SIGNATURE OF DECEASED J. Edgar Hoover	
27. SIGNATURE OF DECEASED J. Edgar Hoover		28. SIGNATURE OF DECEASED J. Edgar Hoover	
29. SIGNATURE OF DECEASED J. Edgar Hoover		30. SIGNATURE OF DECEASED J. Edgar Hoover	
31. SIGNATURE OF DECEASED J. Edgar Hoover		32. SIGNATURE OF DECEASED J. Edgar Hoover	
33. SIGNATURE OF DECEASED J. Edgar Hoover		34. SIGNATURE OF DECEASED J. Edgar Hoover	
35. SIGNATURE OF DECEASED J. Edgar Hoover		36. SIGNATURE OF DECEASED J. Edgar Hoover	
37. SIGNATURE OF DECEASED J. Edgar Hoover		38. SIGNATURE OF DECEASED J. Edgar Hoover	
39. SIGNATURE OF DECEASED J. Edgar Hoover		40. SIGNATURE OF DECEASED J. Edgar Hoover	
41. SIGNATURE OF DECEASED J. Edgar Hoover		42. SIGNATURE OF DECEASED J. Edgar Hoover	
43. SIGNATURE OF DECEASED J. Edgar Hoover		44. SIGNATURE OF DECEASED J. Edgar Hoover	
45. SIGNATURE OF DECEASED J. Edgar Hoover		46. SIGNATURE OF DECEASED J. Edgar Hoover	
47. SIGNATURE OF DECEASED J. Edgar Hoover		48. SIGNATURE OF DECEASED J. Edgar Hoover	
49. SIGNATURE OF DECEASED J. Edgar Hoover		50. SIGNATURE OF DECEASED J. Edgar Hoover	
51. SIGNATURE OF DECEASED J. Edgar Hoover		52. SIGNATURE OF DECEASED J. Edgar Hoover	
53. SIGNATURE OF DECEASED J. Edgar Hoover		54. SIGNATURE OF DECEASED J. Edgar Hoover	
55. SIGNATURE OF DECEASED J. Edgar Hoover		56. SIGNATURE OF DECEASED J. Edgar Hoover	
57. SIGNATURE OF DECEASED J. Edgar Hoover		58. SIGNATURE OF DECEASED J. Edgar Hoover	
59. SIGNATURE OF DECEASED J. Edgar Hoover		60. SIGNATURE OF DECEASED J. Edgar Hoover	
61. SIGNATURE OF DECEASED J. Edgar Hoover		62. SIGNATURE OF DECEASED J. Edgar Hoover	
63. SIGNATURE OF DECEASED J. Edgar Hoover		64. SIGNATURE OF DECEASED J. Edgar Hoover	
65. SIGNATURE OF DECEASED J. Edgar Hoover		66. SIGNATURE OF DECEASED J. Edgar Hoover	
67. SIGNATURE OF DECEASED J. Edgar Hoover		68. SIGNATURE OF DECEASED J. Edgar Hoover	
69. SIGNATURE OF DECEASED J. Edgar Hoover		70. SIGNATURE OF DECEASED J. Edgar Hoover	
71. SIGNATURE OF DECEASED J. Edgar Hoover		72. SIGNATURE OF DECEASED J. Edgar Hoover	
73. SIGNATURE OF DECEASED J. Edgar Hoover		74. SIGNATURE OF DECEASED J. Edgar Hoover	
75. SIGNATURE OF DECEASED J. Edgar Hoover		76. SIGNATURE OF DECEASED J. Edgar Hoover	
77. SIGNATURE OF DECEASED J. Edgar Hoover		78. SIGNATURE OF DECEASED J. Edgar Hoover	
79. SIGNATURE OF DECEASED J. Edgar Hoover		80. SIGNATURE OF DECEASED J. Edgar Hoover	
81. SIGNATURE OF DECEASED J. Edgar Hoover		82. SIGNATURE OF DECEASED J. Edgar Hoover	
83. SIGNATURE OF DECEASED J. Edgar Hoover		84. SIGNATURE OF DECEASED J. Edgar Hoover	
85. SIGNATURE OF DECEASED J. Edgar Hoover		86. SIGNATURE OF DECEASED J. Edgar Hoover	
87. SIGNATURE OF DECEASED J. Edgar Hoover		88. SIGNATURE OF DECEASED J. Edgar Hoover	
89. SIGNATURE OF DECEASED J. Edgar Hoover		90. SIGNATURE OF DECEASED J. Edgar Hoover	
91. SIGNATURE OF DECEASED J. Edgar Hoover		92. SIGNATURE OF DECEASED J. Edgar Hoover	
93. SIGNATURE OF DECEASED J. Edgar Hoover		94. SIGNATURE OF DECEASED J. Edgar Hoover	
95. SIGNATURE OF DECEASED J. Edgar Hoover		96. SIGNATURE OF DECEASED J. Edgar Hoover	
97. SIGNATURE OF DECEASED J. Edgar Hoover		98. SIGNATURE OF DECEASED J. Edgar Hoover	
99. SIGNATURE OF DECEASED J. Edgar Hoover		100. SIGNATURE OF DECEASED J. Edgar Hoover	



5838

CERTIFICATE OF DEATH

05826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium Bethesda</u> 5721 Grosvenor Lane				d. STREET ADDRESS <u>2231 California St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Happersett</u> Last <u>Rees</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 October 1899</u>		9. AGE (In years last birthday) <u>59</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cherical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Thomas Henry Rees</u>				14. MOTHER'S MAIDEN NAME <u>Frances Happersett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>(Sister) Mrs. Dorothy Cramer</u> Address <u>2231 California St. N.W. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>5:55</u> a. m. <u>5:55</u> p. m. Month <u>5</u> Day <u>5</u> Year <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5</u> , 19 <u>59</u> , to <u>5-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-5</u> , 19 <u>59</u> , and that death occurred at <u>5:55</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jerome H. Epstein</u> M.D.				ADDRESS (Street, city or town, state) <u>2025- Eye St., N.W., WASH. D.C.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Jerome Epstein</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-7-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sawicki's Sons</u> ADDRESS <u>1756 Pa. Ave. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JOHN J. WILSON		M		45		W		1890		BALTIMORE, MD		1935		BALTIMORE, MD		HEART DISEASE		NATURAL		J. WILSON		J. WILSON	
13. DATE OF INTERMENT		14. PLACE OF INTERMENT		15. NAME OF INTERMENT SOCIETY		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF CEMETERY		20. NAME OF BURIAL PLACE		21. NAME OF BURIAL PLACE		22. NAME OF BURIAL PLACE		23. NAME OF BURIAL PLACE		24. NAME OF BURIAL PLACE	
1935		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD		BALTIMORE, MD	

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BALTIMORE, MD
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THE STATE OF MARYLAND
DEPARTMENT OF HEALTH
BALTIMORE, MD
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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05827

5839

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buck Lodge		c. LENGTH OF STAY IN 1b 1 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simpson Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clinton Middle Monroe Last Rhodes		4. DATE OF DEATH Month 5 Day 20 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 5 Days 20 Hours 19 Min. 59	11. IF UNDER 24 HRS. Months 5 Days 20 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Rhodes		14. MOTHER'S MAIDEN NAME Catherine Buzzard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Flora Rhodes		Address Dickerson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, Acute, 420.1 DUE TO Generalized Arteriosclerosis (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 hours 8 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1953 to 20 May 1959 that I lost s/he the deceased alive on 28 May 1959 and that death occurred at 10:50 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 21 May 59	
ACTUAL SIGNATURE L. M. Smith		M.D. Barnesville, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/59	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR MAY 25 '59	
ADDRESS Barnesville Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

05827

CERTIFICATE OF DEATH

5250

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5721 CERTIFICATE OF DEATH

05828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 56 SILVER SPRING.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM				d. STREET ADDRESS 114 MANCHESTER PLACE			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle JOSEPH Last RITER				4. DATE OF DEATH Month MAY Day 22 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1912		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY SHOES		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS RITER				14. MOTHER'S MAIDEN NAME IDA SCHWARTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO.		17. INFORMANT LOUIS WAYMAN Address 5581-CHILLUM PL NE WASHINGTON D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 HOURS 4 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 1, 1959 , to MAY 22, 1959 , that I last saw the deceased alive on MAY 22, 1959 , and that death occurred at 9:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. Sugar M.D.		ADDRESS (Street, city or town, state) 4300 KAYWOOD DRIVE				DATE SIGNED MAY 22, 1959	
PHYSICIAN'S NAME (Type) Samuel J. Sugar		ADDRESS MT RAINIER, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-26-59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargatzis ADDRESS 3501-14 ST NW.				24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

00858

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

7731 CERTIFICATE OF DEATH

REG. DIST. NO.

DATE OF DEATH		PLACE OF DEATH	
JAN 1 1900		BALTIMORE	
TIME OF DEATH		CAUSE OF DEATH	
10:00 AM		HEART DISEASE	
AGE		SEX	
65		M	
RACE		RELIGION	
WHITE		METHODIST	
BIRTH DATE		BIRTH PLACE	
JAN 1 1835		BALTIMORE	
FATHER'S NAME		MOTHER'S NAME	
JOHN B. SMITH		MARY A. SMITH	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
FARMER		HOUSEWIFE	
EDUCATION		MARRIAGE DATE	
HIGH SCHOOL		1855	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
NONE		NONE	
SIGNS OF DEATH		TIME OF DEATH	
PULSE STOPPED		10:00 AM	
BREATH STOPPED		10:00 AM	
EYES CLOSED		10:00 AM	
MOUTH OPEN		10:00 AM	
SKIN COLORED		10:00 AM	
TEMPERATURE		10:00 AM	
PULSE		10:00 AM	
BLOOD PRESSURE		10:00 AM	
RESPIRATION		10:00 AM	
HEART ACTION		10:00 AM	
LUNGS		10:00 AM	
LIVER		10:00 AM	
SPLEEN		10:00 AM	
PANCREAS		10:00 AM	
GASTROINTESTINAL		10:00 AM	
URINARY		10:00 AM	
GENITAL		10:00 AM	
SKIN		10:00 AM	
MUSCLES		10:00 AM	
BONES		10:00 AM	
TEETH		10:00 AM	
HAIR		10:00 AM	
NAILS		10:00 AM	
EYES		10:00 AM	
EARS		10:00 AM	
NOSE		10:00 AM	
MOUTH		10:00 AM	
THROAT		10:00 AM	
LARYNX		10:00 AM	
TRACHEA		10:00 AM	
BRONCHI		10:00 AM	
LUNGS		10:00 AM	
PERICARDIUM		10:00 AM	
HEART		10:00 AM	
PERITONEUM		10:00 AM	
LIVER		10:00 AM	
GALLBLADDER		10:00 AM	
PANCREAS		10:00 AM	
DUODENUM		10:00 AM	
JEJUNUM		10:00 AM	
ILEUM		10:00 AM	
CAECUM		10:00 AM	
SIGMOID		10:00 AM	
RECTUM		10:00 AM	
ANUS		10:00 AM	
VAGINA		10:00 AM	
UTERUS		10:00 AM	
OVARY		10:00 AM	
TUBES		10:00 AM	
VULVA		10:00 AM	
CLITORIS		10:00 AM	
PENIS		10:00 AM	
SCROTUM		10:00 AM	
TESTES		10:00 AM	
EPIDIDYMIS		10:00 AM	
VASE DEFERENS		10:00 AM	
URETER		10:00 AM	
BLADDER		10:00 AM	
URETHRA		10:00 AM	
PROSTATE		10:00 AM	
VAGINA		10:00 AM	
UTERUS		10:00 AM	
OVARY		10:00 AM	
TUBES		10:00 AM	
VULVA		10:00 AM	
CLITORIS		10:00 AM	
PENIS		10:00 AM	
SCROTUM		10:00 AM	
TESTES		10:00 AM	
EPIDIDYMIS		10:00 AM	
VASE DEFERENS		10:00 AM	
URETER		10:00 AM	
BLADDER		10:00 AM	
URETHRA		10:00 AM	
PROSTATE		10:00 AM	

2000

BALTIMORE, MD.

5840 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium</u>				d. STREET ADDRESS <u>7705 Morningside Drive</u> NY. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Shields</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>26 Feb 1873</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Shields</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Niece, Mrs. James H. Rees</u>		Address <u>7705 Morningside Wash D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Sclerosis</u> DUE TO (c) <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture right hip - operated - Feb 24, 1959</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 2</u> , 19 <u>59</u> to <u>May 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert B. Havell</u>				M.D. <u>5516 Neb. Ave. D.C. 5-6-59</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros. 1661-9th St</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5841 CERTIFICATE OF DEATH

05830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Stafford (City)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stafford 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hosp. NNM, Bethesda, Md.		d. STREET ADDRESS RFD #4, Box 339	
3. NAME OF DECEASED (Type or print) Thomas Edward ROLLINS		4. DATE OF DEATH Month May Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-87
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 74 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Simond ROLLINS		14. MOTHER'S MAIDEN NAME Susan Ann WHITE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes U. S. Army		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE (UREMIA) 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC BILATERAL NEPHROSCLEROSIS DUE TO (c) CHRONIC INFECTION AND HYPERTENSION			
INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 10 YEARS 10 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE & CONGESTIVE FAILURE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 May , 19 59 , to 24 May , 19 59 , that I last saw the deceased alive on 24 May , 19 59 , and that death occurred at 0333 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. S. Caldwell		ADDRESS (Street, city or town, state) DATE SIGNED U. S. NAVAL HOSPITAL, BETHESDA, MD.	
PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT MC, USN		U.S. NAVAL HOSPITAL, BETHESDA, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-26-59	
22c. NAME OF CEMETERY OR CREMATORY UNIONVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) STAFFORD VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. JARVIS		24a. REC'D BY REGISTRAR DATE MAY 26 '59	
ADDRESS 1432 "U" STREET N.W. WASH, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5842 CERTIFICATE OF DEATH

05831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u> MD c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>1522 LIVE OAK DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Julia ANNA Russell</u>		4. DATE OF DEATH Month Day Year <u>5 31 19 59</u>	
5. SEX <u>Fe</u> COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/20/73</u> 9. AGE (In years lost birthday) <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Valentine Makre</u>		14. MOTHER'S MAIDEN NAME <u>Frances Hans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Jesse M. Eader</u> <u>1522 Live Oak Drive, Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 d.</u> ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1958</u> to <u>31 May 1959</u> that I last saw the deceased alive on <u>30 May 1959</u> and that death occurred at <u>9:42 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Aud</u> M.D.		ADDRESS (Street, city or town, state) <u>906 Lakeside Rd Silver Spring, Md</u> DATE SIGNED <u>5/31/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>		PHYSICIAN'S ADDRESS <u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

18331

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1. Name of deceased JOHN BROWN		2. Sex Male	
3. Date of birth Jan 15, 1880		4. Age 35	
5. Place of birth St. Louis, Mo.		6. Race White	
7. Occupation Engineer		8. Cause of death Heart disease	
9. Date of death Feb 10, 1915		10. Place of death Home	
11. Signature of physician J. H. Smith		12. Signature of registrar W. H. Jones	
13. Signature of informant Mrs. J. Brown		14. Signature of witness John Doe	
15. Date of filing Feb 15, 1915		16. Registrar's office Baltimore, Md.	

DEPARTMENT OF HEALTH
BALTIMORE, MD

RECEIVED
FEB 15 1915
BALTIMORE, MD

5843

CERTIFICATE OF DEATH

05832

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. NAME OF HOSPITAL (If not in hospital, give street address) 6406 Western Avenue		MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 6406 Western Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH M. SCHLAUDECKER		4. DATE OF DEATH Month May 31, Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1870
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR: Months 0 Days 18 Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Erie, Pa.
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Frank Hoffmann	
14. MOTHER'S MAIDEN NAME Kathryn ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT John A. Schlaudecker-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency of Mo- 420.0 DUE TO Arterio-sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yr - DUE TO (c) 18 yr -		INTERVAL BETWEEN ONSET AND DEATH 10 yr -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Nov 1958 , to 31 May 1959 , that I last saw the deceased alive on 30 May 1959 , and that death occurred at 12:12 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5522 Western Ave DATE SIGNED Cheng Chen is MD ACTUAL SIGNATURE Art. Richwine M.D. PHYSICIAN'S NAME (Type) ART. RICHWINE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Transit		22b. DATE THEREOF 5/31/59	
22c. NAME OF CEMETERY OR CREMATORY Trinity		22d. LOCATION (City, town, or county) (State) Erie, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JUN 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15231

5722

CERTIFICATE OF DEATH

Reg. Dist. No. 05833

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>12 1/2 hrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>				d. STREET ADDRESS <u>60 University Blvd. E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clara Regina Schelle</u>				4. DATE OF DEATH <u>5-16-1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-6-21</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>BURKHAMMER</u>				14. MOTHER'S MAIDEN NAME <u>Florence Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>168-20-4982</u>		17. INFORMANT <u>Hospital Records.</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - metast. prob. in CNS</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Colon</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 12, 1943</u> , to <u>16 May, 1959</u> , that I last saw the deceased alive on <u>15 May, 1959</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Takoma Park 12, Md.</u>				DATE SIGNED <u>5/16/59</u>			
ACTUAL SIGNATURE <u>W. P. McNeill</u>				M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>W. P. McNeill, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5844

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 15834

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>221 Deer Park Dr.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Otis Grant Shippe</u>			4. DATE OF DEATH Month Day Year <u>May 2 1959 19</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/1899</u>		9. AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>John Hopkins Lab</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Berlinton, Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>Benjamin Shippe</u>			14. MOTHER'S MAIDEN NAME <u>Dora Moyer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Wife (Same as Above)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amputation of brain stem</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) <u>Fractures of C-1 & C-2 with compression of cord</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple injuries, extreme</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto involved in head on collision</u>			
20c. TIME OF INJURY Month, Day, Year <u>7:15 a.m. 5/2/59 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) (County) (State) <u>nr Gaithersburg Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>May 2, 1959</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '59</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

Brought in 8:15 A.M. by Rockville Rescue Squad D.O.A.

8244

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

82236

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES H. HARRIS		45		M		W		C	
RESIDENCE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1212 N. E. St.		10/10/1918		10:30 AM		HOME		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
Carpenter		8 Years		Yes		10 Years		Yes	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING	
None		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CAUSE	
J. H. HARRIS		10/10/1918		10:30 AM		HOME		HEART DISEASE	

5845 - CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Nassau</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Malverne</u> 69X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>653 Cornwell Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Siegel</u> Last <u>Siegel</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Rosenblum</u>		14. MOTHER'S MAIDEN NAME <u>Pearl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Mac Brachfeld - Same - Daughter</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct due to Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/13/59</u> to <u>5/14/59</u> , that I last saw the deceased alive on <u>5/14/59</u> , 19 <u>59</u> , and that death occurred at <u>5:36</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.		ADDRESS (Street, city or town, state) <u>106 20 Georgia Ave</u> DATE SIGNED <u>5/14/59</u>	
PHYSICIAN'S NAME (Type) <u>John J. Curry, M.D.</u>			
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/17-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>United Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Staten Island N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217-92d Ave</u>		24c. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>
DATE <u>5/18/59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5723 CERTIFICATE OF DEATH

Reg. Dist. No.

05836

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 1617-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San & Hosp.				d. STREET ADDRESS 1118 Lancaster Rd.			
3. NAME OF DECEASED (Type or print) Frances Isabel Small				4. DATE OF DEATH 5 22 1959			
5. SEX Wife		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/29/12	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Charles Olen Heavenee				14. MOTHER'S MAIDEN NAME Addie Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT PT's hosp. Record Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma Multiforme (Lymphoma Grade 3) 193.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 29 , 19 59 , to May 22 , 19 59 , that I last saw the deceased alive on May 22 , 19 59 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6101 New Hampshire Ave. Wash D.C. DATE SIGNED 5/22/59							
ACTUAL SIGNATURE Leo J. Schildhaus M.D.							
PHYSICIAN'S NAME (Type) Leo J. Schildhaus							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Hines Co. 2901-14 St. N.W. ADDRESS				24a. REC'D BY REGISTRAR DATE 5/27/59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5846 CERTIFICATE OF DEATH

Reg. Dist. No.

05837

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Wilcox Smith</u>				4. DATE OF DEATH Month Day Year <u>MAY 31 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 9, 1876</u>	9. AGE (In years, last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>x</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Littleton Smith</u>				14. MOTHER'S MAIDEN NAME <u>Suzanna Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Asbury Methodist Home Gaithersburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebral vascular accident</u> DUE TO <u>anticoagulation</u> (c) <u>anticoagulation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-10-59</u> <u>5-11-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-3</u> 19 <u>58</u> , to <u>May 31</u> 19 <u>59</u> , that I last saw the deceased alive on <u>5-27</u> 19 <u>59</u> , and that death occurred at <u>12:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah E Glover</u> M.D.				ADDRESS (Street, city or town, state) <u>10128 CEDAR LAVE KENSINGTON, Md</u>		DATE SIGNED <u>5-31-59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Sarah Elizabeth Glover</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mr. J. Pickner & Sons - Balto 17 Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. *Chlorophyll a* (Chl a) and *Chlorophyll b* (Chl b) are the two main photosynthetic pigments in green plants. They are responsible for capturing light energy and converting it into chemical energy through the process of photosynthesis. Chl a is the primary pigment, while Chl b acts as an accessory pigment, transferring energy to Chl a.

1 6 M 051 1 2 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 6 M 051 1 2 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5847 CERTIFICATE OF DEATH

Reg. Dist. No.

05838

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St Louis City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St Louis 62X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 3176 Gustine St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jane Phyllis SMITH		4. DATE OF DEATH Month Day Year May 21 19 59	
5. SEX female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1921
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert WANDER		14. MOTHER'S MAIDEN NAME Norine O'BRIAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 500-18-0971	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malignant pheochromocytoma 1950 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 mo.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21 , 19 59 , to May 21 , 19 59 , that I last saw the deceased alive on May 21 , 19 59 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Sengstack		ADDRESS (Street, city or town, state) USNH Bethesda, Md	
DATE SIGNED			
PHYSICIAN'S NAME (Type) G. F. SENGSTACK, LT, MC, USN		U.S. NAVAL HOSPITAL, BETHESDA, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 May 1959	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) St Louis Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY		ADDRESS 7557 Wisconsin Ave., Bethesda, Md	
24a. REC'D BY REGISTRAR MAY 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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• 2 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05839

5848

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Newark c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 67X-3 d. STREET ADDRESS 590 North Sixth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Shirley May Smith		4. DATE OF DEATH Month Day Year May 10, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1933
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Smith		14. MOTHER'S MAIDEN NAME Mae O'Neill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 135-26-9626	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Ventricular septal defect with congestive failure and intrathoracic hemorrhage (post-operative) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXXX			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 26 , 19 59 , to May 10 , 19 59 , that I last saw the deceased alive on May 10 , 19 59 , and that death occurred at 2:18a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 5-10-59			
ACTUAL SIGNATURE William P. Cornell		M.D. William P. Cornell, M. D.	
PHYSICIAN'S NAME (Type) William P. Cornell, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/13/59	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Manover, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chamberlin Co.		ADDRESS 1400 Chapin St. N.W., Ac	
24a. REC'D BY REGISTRAR DATE MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

5868

File No. 12

LOCAL BOARD OF HEALTH

REPORT

DATE OF DEATH

11/20/30

TIME OF DEATH

10:30 A.M.

PLACE OF DEATH

Home

AGE

22

SEX

Male

RACE

White

EDUCATION

High School

OCCUPATION

Student

CAUSE OF DEATH

Heart Disease

MODE OF DEATH

Natural

DATE OF REPORT

11/20/30

SIGNATURE

Dr. J. H. Smith

REPORT MADE BY

Dr. J. H. Smith

DATE OF REPORT

11/20/30

SIGNATURE

Dr. J. H. Smith

REPORT MADE BY

Dr. J. H. Smith

DATE OF REPORT

11/20/30

SIGNATURE

Dr. J. H. Smith

REPORT MADE BY

Dr. J. H. Smith

DATE OF REPORT

11/20/30

SIGNATURE

Dr. J. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5849 CERTIFICATE OF DEATH

Reg. Dist. No. 05840

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75 x 3 d. STREET ADDRESS 6962 Ogontz Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Tillie (none) Snyderman				4. DATE OF DEATH Month Day Year May 11, 1959											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1890		9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator's Helper				10b. KIND OF BUSINESS OR INDUSTRY Ladies' Clothing				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Gabriel Snyderman				14. MOTHER'S MAIDEN NAME Sarah Forman											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Synovium Metastatic to Lungs 1979 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 6 , 19 59 , to May 11 , 19 59 , that I last saw the deceased alive on May 11 , 19 59 , and that death occurred at 7:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/12/59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5/13-1959		22c. NAME OF CEMETERY OR CREMATORY Harlem		22d. LOCATION (City, town, or county) (State) Philadelphia Pa							
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home Wash DC						ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Huns					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5850

CERTIFICATE OF DEATH

Reg. Dist. No. 05841

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG				c. LENGTH OF STAY IN 1b Appr. 4 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Henry J. Stanowsky				4. DATE OF DEATH Month Day Year May 20 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/9/87	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER (retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JULIUS HENRY STANOWSKY				14. MOTHER'S MAIDEN NAME MARY LOUISE REX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-07-4241		17. INFORMANT Address Mrs. Minnie C. Stanowsky, Clarksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15, 1958 to 5/20, 1959 , that I last saw the deceased alive on 5/18, 1959 , and that death occurred at 8:10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James D. Kerr				ADDRESS (Street, city or town, state) Womansens, Md.		DATE SIGNED 5/20/59	
PHYSICIAN'S NAME (Type) JAMES D. KERR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/23/59		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAY 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 103841

PLACE OF DEATH HOME		MANNER OF DEATH ACCIDENTAL		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 10 1960		TIME OF DEATH 10:00 AM		PLACE OF BIRTH BALTIMORE, MD	
SEX MALE		AGE 68		RACE WHITE	
OCCUPATION RETIRED		PREVIOUS ILLNESS YES		DATE OF LAST ILLNESS DEC 15 1959	
NAME OF DECEASED JOHN J. SMITH		NAME OF NEXT OF KIN MARY J. SMITH		ADDRESS 1234 E. BALTIMORE AVE. BALTIMORE, MD 21201	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN MARY J. SMITH		SIGNATURE OF PHYSICIAN DR. J. H. BROWN	
SIGNATURE OF REGISTRAR J. H. BROWN		SIGNATURE OF CLERK J. H. BROWN		SIGNATURE OF NURSE J. H. BROWN	

1

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE CORRECT. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH. IT IS THE DUTY OF THE CLERK TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE CORRECT. IT IS THE DUTY OF THE NURSE TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE CORRECT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5851

CERTIFICATE OF DEATH

05842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp-</u>		d. STREET ADDRESS <u>17505-Brookville Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Miller</u> Middle <u>B.</u> Last <u>Stevinson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28-1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Anson & Gilker Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Christopher S. Stevenson</u>	
14. MOTHER'S MAIDEN NAME <u>Sara unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>579-01-1781</u>		17. INFORMANT <u>John R. Blake</u> Address <u>1732 Taylor St. N.W. Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute uremia</u> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>48 days</u> <u>7 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>home</u> , 19 <u>58</u> , to <u>17 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13 MAY</u> , 19 <u>59</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>17 May 59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>MAY 19 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 96 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 76 Forrester Street, S. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Francis Glonleau Steward, Jr.		4. DATE OF DEATH Month May Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1915
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 12 Hours 12 Min.	11. IF UNDER 24 HRS. Months 4 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Apartment Upkeeping	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Steward		14. MOTHER'S MAIDEN NAME Mary E. Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 577-24-6486	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 5, 1959 to May 12, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 5:34 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 5/12/59			
ACTUAL SIGNATURE Edgar Haber		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) EDGAR HABER, M.D.		The National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-15-59	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) FT. MYER, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Pope		ADDRESS 414-15th St. S.E. WASH., D.C.	
24a. REC'D BY REGISTRAR DATE MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Pope	

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

See 201.1-1

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Manner of death: [illegible]
10. Signature of physician: [illegible]
11. Signature of registrar: [illegible]
12. Date of registration: [illegible]

13. Name of informant: [illegible]
14. Relationship to deceased: [illegible]
15. Date of information: [illegible]
16. Signature of informant: [illegible]
17. Signature of registrar: [illegible]
18. Date of registration: [illegible]
19. Name of registrar: [illegible]
20. Title of registrar: [illegible]
21. Office of registrar: [illegible]
22. Date of registration: [illegible]
23. Signature of registrar: [illegible]
24. Date of registration: [illegible]
25. Signature of registrar: [illegible]
26. Date of registration: [illegible]
27. Signature of registrar: [illegible]
28. Date of registration: [illegible]
29. Signature of registrar: [illegible]
30. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5853

CERTIFICATE OF DEATH

Reg. Dist. No.

05844

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 10 MIN.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS Rt. #1 HOMECREST ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY		First		Middle		Last		4. DATE OF DEATH MAY 24		Month		Day		Year 19 59					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 24, 1959		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours 10					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME HAROLD WADE STRICKLAND						14. MOTHER'S MAIDEN NAME ELLEN MARY SMITH													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS				Address OLNEY, MARYLAND									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x DUE TO Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 19 wks gestation - 11 oz. weight. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from MAY 24 , 19 59 , to MAY 24 , 19 59 , that I last saw the deceased alive on MAY 24 , 19 59 , and that death occurred at 12:35 A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5/25/59																			
ACTUAL SIGNATURE Richard A. Yates				M.D.				PHYSICIAN'S NAME (Type) R. A. YATES, M. D.				ADDRESS OLNEY, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 5/27/59				22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY				22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.				ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE MAY 27 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5854

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WASHINGTON b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.			
c. LENGTH OF STAY IN 1b 4 MONTHS				d. STREET ADDRESS 38 MILMARSON PL. N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROPINE NURSING Home; River Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle E. Last Taylor				4. DATE OF DEATH Month MAY Day 31 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 JAN 1859	9. AGE (In years last birthday) 100 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address R.M. STRICKBOTT, 9919 Logan Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Generalized Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 29 Jan , 19 59 , to 31 May , 19 59 , that I last saw the deceased alive on 29 May , 19 59 , and that death occurred at 6:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2029 Que St., N.W. DATE SIGNED 5-31-59							
ACTUAL SIGNATURE W. F. Cresswell Jr. M.D.		PHYSICIAN'S NAME (Type) W. F. Cresswell WASHINGTON, D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Burial	6-3-59	Fairview Rock Creek		Washington D.C.		DC	
23. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME		ADDRESS WASHINGTON D.C.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Arthur S. Hume		
		4812 GA. AVE. NW		DATE JUN 3 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5855 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS Route #2			
3. NAME OF DECEASED (Type or print) First Julia Middle Holton Last Thompson				4. DATE OF DEATH Month May Day 13 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-28-88	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Isaac Iglehart				14. MOTHER'S MAIDEN NAME Josephine Stansfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Thoracic aneurysm OF AORTA 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thoracic aneurysm OF AORTA DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive arteriosclerotic cardiovascular renal disease.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from JULY , 1947, to MAY 12 , 1959, that I last saw the deceased alive on MAY 12 , 1959, and that death occurred at 1:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles S. Whitaker M.D.				DATE SIGNED 5.13.59			
PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.				ADDRESS Clarksville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/15/59		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Alpha, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham				ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR MAY 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

100-100

<p>1. Name of deceased: James E. Holtzman</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: May 13, 1913</p>		<p>4. Age: 27 years</p>	
<p>5. Date of death: May 13, 1940</p>		<p>6. Place of death: St. Joseph's Hospital, Baltimore, Md.</p>	
<p>7. Cause of death: Myocardial infarction</p>		<p>8. Duration of illness: 2 days</p>	
<p>9. Place of birth: Baltimore, Md.</p>		<p>10. Occupation: None</p>	
<p>11. Signature of physician: James E. Holtzman</p>		<p>12. Signature of registrar: James E. Holtzman</p>	
<p>13. Date of registration: May 13, 1940</p>		<p>14. Place of registration: Baltimore, Md.</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5856 CERTIFICATE OF DEATH

Reg. Dist. No.

05847

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Herndon 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route #3	
3. NAME OF DECEASED (Type or print) First Sharon Middle Marie Last Thorpe		4. DATE OF DEATH Month May Day 7 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1954
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 12 Hours 25 Min.	11. IF UNDER 24 HRS. Months 4 Days 12 Hours 25 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman O. Thorpe		14. MOTHER'S MAIDEN NAME Carrie Holdaway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LYMPHOCYTIC LEUKEMIA 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 6 1/2 MRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from March 31, 19 59 to May 7, 19 59 , that I last saw the deceased alive on May 7, 19 59 , and that death occurred at 9:15a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Richard Lee M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 5/7/59	
PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)*
Removal - Burial - May 10, 1959 - Chestnut Grove Cemetery			Herndon, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE J. Berkeley Smith		ADDRESS Herndon, Va.	
24a. REC'D BY REGISTRAR MAY 12 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kinn	

CERTIFICATE OF DEATH

2238

1911

<p>1. Name of deceased: <i>William H. Jones</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of death: <i>July 23, 1911</i></p>	
<p>5. Place of death: <i>Home</i></p>		<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>Wm. H. Jones</i></p>		<p>8. Signature of registrar: <i>Wm. H. Jones</i></p>	
<p>9. Signature of witness: <i>Wm. H. Jones</i></p>		<p>10. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>11. Signature of witness: <i>Wm. H. Jones</i></p>		<p>12. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>13. Signature of witness: <i>Wm. H. Jones</i></p>		<p>14. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>15. Signature of witness: <i>Wm. H. Jones</i></p>		<p>16. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>17. Signature of witness: <i>Wm. H. Jones</i></p>		<p>18. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>19. Signature of witness: <i>Wm. H. Jones</i></p>		<p>20. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>21. Signature of witness: <i>Wm. H. Jones</i></p>		<p>22. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>23. Signature of witness: <i>Wm. H. Jones</i></p>		<p>24. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>25. Signature of witness: <i>Wm. H. Jones</i></p>		<p>26. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>27. Signature of witness: <i>Wm. H. Jones</i></p>		<p>28. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>29. Signature of witness: <i>Wm. H. Jones</i></p>		<p>30. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>31. Signature of witness: <i>Wm. H. Jones</i></p>		<p>32. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>33. Signature of witness: <i>Wm. H. Jones</i></p>		<p>34. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>35. Signature of witness: <i>Wm. H. Jones</i></p>		<p>36. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>37. Signature of witness: <i>Wm. H. Jones</i></p>		<p>38. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>39. Signature of witness: <i>Wm. H. Jones</i></p>		<p>40. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>41. Signature of witness: <i>Wm. H. Jones</i></p>		<p>42. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>43. Signature of witness: <i>Wm. H. Jones</i></p>		<p>44. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>45. Signature of witness: <i>Wm. H. Jones</i></p>		<p>46. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>47. Signature of witness: <i>Wm. H. Jones</i></p>		<p>48. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>49. Signature of witness: <i>Wm. H. Jones</i></p>		<p>50. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>51. Signature of witness: <i>Wm. H. Jones</i></p>		<p>52. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>53. Signature of witness: <i>Wm. H. Jones</i></p>		<p>54. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>55. Signature of witness: <i>Wm. H. Jones</i></p>		<p>56. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>57. Signature of witness: <i>Wm. H. Jones</i></p>		<p>58. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>59. Signature of witness: <i>Wm. H. Jones</i></p>		<p>60. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>61. Signature of witness: <i>Wm. H. Jones</i></p>		<p>62. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>63. Signature of witness: <i>Wm. H. Jones</i></p>		<p>64. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>65. Signature of witness: <i>Wm. H. Jones</i></p>		<p>66. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>67. Signature of witness: <i>Wm. H. Jones</i></p>		<p>68. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>69. Signature of witness: <i>Wm. H. Jones</i></p>		<p>70. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>71. Signature of witness: <i>Wm. H. Jones</i></p>		<p>72. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>73. Signature of witness: <i>Wm. H. Jones</i></p>		<p>74. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>75. Signature of witness: <i>Wm. H. Jones</i></p>		<p>76. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>77. Signature of witness: <i>Wm. H. Jones</i></p>		<p>78. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>79. Signature of witness: <i>Wm. H. Jones</i></p>		<p>80. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>81. Signature of witness: <i>Wm. H. Jones</i></p>		<p>82. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>83. Signature of witness: <i>Wm. H. Jones</i></p>		<p>84. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>85. Signature of witness: <i>Wm. H. Jones</i></p>		<p>86. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>87. Signature of witness: <i>Wm. H. Jones</i></p>		<p>88. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>89. Signature of witness: <i>Wm. H. Jones</i></p>		<p>90. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>91. Signature of witness: <i>Wm. H. Jones</i></p>		<p>92. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>93. Signature of witness: <i>Wm. H. Jones</i></p>		<p>94. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>95. Signature of witness: <i>Wm. H. Jones</i></p>		<p>96. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>97. Signature of witness: <i>Wm. H. Jones</i></p>		<p>98. Signature of witness: <i>Wm. H. Jones</i></p>	
<p>99. Signature of witness: <i>Wm. H. Jones</i></p>		<p>100. Signature of witness: <i>Wm. H. Jones</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05848

Reg. Dist. No. 215

5857

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Ruxxa) c. LENGTH OF STAY IN lb 36 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 47X-3 d. STREET ADDRESS 300 T Street, N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Vernon Lawson UPDEGROVE				4. DATE OF DEATH Month Day Year May 9 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-8-17	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher				10b. KIND OF BUSINESS OR INDUSTRY Food Store		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank E. UPDEGROVE				14. MOTHER'S MAIDEN NAME Hazel SENNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1940-1945		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinomatosis 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma, Pancreas DUE TO (c) 18 mos							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3 , 19 59 , to May 9 , 19 59 , that I last saw the deceased alive on May 8 , 19 59 , and that death occurred at 3:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Troy				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC			
DATE SIGNED 5-9-59							
PHYSICIAN'S NAME (Type) John W. TROY, CDR, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-13-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS Wash., DC		24a. REC'D BY REGISTRAR MAY 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(272)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G242 5-11-59 et

CERTIFICATE OF DEATH

05849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8911 1/2 - Montgomery Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert E. Wade</u>		4. DATE OF DEATH Month <u>5</u> - Day <u>1</u> - Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas J Wade</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>225-05-4815</u>	
17. INFORMANT <u>Mrs Franklin Beavers - same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive heart failure</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1959</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/18/59</u> 19 <u> </u> , to <u>5/1</u> 19 <u>59</u> , that I last saw the deceased alive on <u>5/1</u> 19 <u>59</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhoeu</u> M.D.		ADDRESS (Street, city or town, state) <u>8805 Conn Ave.</u> DATE SIGNED <u>5/1/59</u>	
PHYSICIAN'S NAME (Type) <u>John B. Umhoeu</u>		<u>Chevy Chase 15 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home -</u>		ADDRESS <u>Washington D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05850

5859

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY in 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Home</u>				d. STREET ADDRESS <u>3312 University Blvd., West</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roberta</u> Middle <u>Lee</u> Last <u>Wandling</u>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 3 XXXXX 1871</u>		9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Adjudicator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN WANDLING</u>				14. MOTHER'S MAIDEN NAME <u>JANE EVANS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Eliz Smith</u> Address <u>3605 Dupont Ave. Kensington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Apr 1 month</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma of Uterus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr</u> , 1955, to <u>May 4</u> , 1959, that I last saw the deceased alive on <u>May 4</u> , 1959, and that death occurred at <u>12:36 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10110 Georgia Ave 5/4/59</u>							
ACTUAL SIGNATURE <u>John Lawrence Avery</u> M.D.				SILVER SPRING, MD			
PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>5/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELMWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>OWENSBORO, KENTUCKY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond C. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05851

Reg. Dist. No.

5860

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Conn. b. COUNTY New Haven	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 2 1/2 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meriden 45 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 560 New Hanover Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Everett Middle A. Last Ward		4. DATE OF DEATH Month May Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 10 Days 21	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Machinist	11. BIRTHPLACE (State or foreign country) Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Fredrick Ward		14. MOTHER'S MAIDEN NAME (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 042-14-7768	
17. INFORMANT Son in Law (Robert Roosa)		Address 4210 South End Rd. Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Thrombosis (c) Arteriosclerosis DUE TO (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 7 hrs ? years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschert		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 5-21-59		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans 5/21/59		22b. DATE THEREOF 5/21/59	22c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cem.
22d. LOCATION (City, town, or county) (State) Meriden, Connecticut			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAY 25 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8860

8860

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		M		45		JAN 15 1950		BOSTON, MASS.	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE OR INJURY		LOCALITY		CITY	
NATURAL		HEART DISEASE		CORONARY ARTERY DISEASE		BOSTON		MASS.	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE	
JAN 15 1950		10:00 AM		BOSTON		J. J. JONES		M.D.	
DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL		SIGNATURE OF BURIAL OFFICER		TITLE	
JAN 15 1950		10:00 AM		BOSTON		J. J. JONES		M.D.	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSE</u> Middle <u>GARNETT</u> Last <u>WARD</u>		4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1882</u>
9. AGE (In years lost birthday) yrs. <u>77</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217036-6714</u>	
17. INFORMANT <u>Ouida J. Ward</u>		Address <u>Same Wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>526x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchitis</u> (c) <u>Chronic Bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs</u> <u>Indeterminate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>gen. arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1957</u> to <u>5/30/1959</u> , that I last saw the deceased alive on <u>5/30/1959</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>5/30/59</u>	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		<u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Darnestown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 FilmG243 6-2-59 et

05853

5862

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		STATE Maryland		COUNTY Montgomery			
CITY (If outside corporate limits, write RURAL and give nearest town) Cedar Grove		LENGTH OF STAY (in this place) 80 Years		CITY (If outside corporate limits, write RURAL and give nearest town) Cedar Grove			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. Germantown		STREET ADDRESS (If rural give location) R.F.D. Germantown					
3. NAME OF DECEASED (First) Vertie (Middle) A. (Last) Watkins				4. DATE OF DEATH (Month) May (Day) 22 (Year) 1959			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 27 1873	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Mullinix				14. MOTHER'S MAIDEN NAME Elizabeth Bowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mable A. Tregoning Same As 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) Anteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH 10 years			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 31/10, 1948, to 5/17, 1959, that I last saw the deceased alive on 5/17, 1959, and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
SIGNATURE James P. Kover				DATE SIGNED 5/13/59			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF May 25 59		NAME OF CEMETERY OR CREMATORY Salem Methodist	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE Clifford S. Kinner		25. FUNERAL DIRECTOR'S SIGNATURE Royce Barber	
DATE MAY 27 '59				ADDRESS (Street, city, town, state) Cedar Grove Md.		ADDRESS Laytonsville, Md	

62223

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

5862

REG. NO. 18

1. NAME OF DECEASED

John William Jones

2. PLACE OF BIRTH

St. Louis, Mo.

3. SEX

Male

4. AGE

45 years

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF COURT

18. SIGNATURE OF STATE

19. SIGNATURE OF COUNTY

20. SIGNATURE OF CITY

21. SIGNATURE OF TOWN

22. SIGNATURE OF VILLAGE

23. SIGNATURE OF POST OFFICE

RECEIVED
BALTIMORE
MAY 18 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05854

CERTIFICATE OF DEATH

Reg. Dist. No.

5863

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Hunting Hill c. LENGTH OF STAY IN 1b 50 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Hunting Hill d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle B. Last WHALEN		4. DATE OF DEATH Month May 17, Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hamilton Crown		14. MOTHER'S MAIDEN NAME Sarah Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT William M. Whalen-Rockville, Md.-Son		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right breast, with metastasis to liver & lungs DUE TO (This patient refused surgery) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (This patient refused surgery) INTERVAL BETWEEN ONSET AND DEATH 3 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity & Hypertension - 5 years.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month May Day 17 Year 1959 Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 17		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19____, to May 17 , 19 59 , that I last saw the deceased alive on May 17 , 19 59 , and that death occurred at 14 from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 N. Summit Ave. - 5/18/59. DATE SIGNED Garthburg, Md.			
ACTUAL SIGNATURE William A. Linthicum M.D.		PHYSICIAN'S NAME (Type) William A. Linthicum	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-20-59	22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		24a. REC'D BY REGISTRAR DATE MAY 19 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05855

5864

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		d. STREET ADDRESS 3913 Ingomar St N.W.	
3. NAME OF DECEASED (Type or print) Beulah		4. DATE OF DEATH Month May Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1868
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper (retired)		10b. KIND OF BUSINESS OR INDUSTRY Tenn.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Al. Whitaker		14. MOTHER'S MAIDEN NAME Hester Trundle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Address Mrs Samuel Huey-3913-Ingomar St. N.W.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, advanced DUE TO (c) Arteriosclerosis, general advanced	
INTERVAL BETWEEN ONSET AND DEATH 10 min		3 yrs x 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington		(County) (State)	
21. I certify that I attended the deceased from 1953 to May 16, 1959 , that I last saw the deceased alive on 5/12/1959 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St N.W. Wash DC DATE SIGNED 5/16/59			
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St N.W. Wash DC	
PHYSICIAN'S NAME (Type) Stewart Clapp		Wash DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY Monacacy		22d. LOCATION (City, town, or county) (State) Beallsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR MAY 19 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

05856

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash San & Hosp</u>				d. STREET ADDRESS <u>7914 13th St N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Wines</u>				4. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-82</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levine Schenck</u>				14. MOTHER'S MAIDEN NAME <u>Mary Moerder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Hosp Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from ruptured aorta 9 days</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatitis</u> DUE TO <u>1 year</u> (c) <u>sigmoid colon adenocarcinoma, metastatic brain</u> DUE TO <u>2 1/2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 July</u> , 19 <u>58</u> , to <u>14 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13 May</u> , 19 <u>59</u> , and that death occurred at <u>1:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Seruch T. Kimble</u>				M.D. <u>929 Pennsylvania Ave. S.E., Wash. D.C.</u> <u>14 May 59</u>			
PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/16/59</u>		<u>ROCK CREEK CEMETERY</u>		<u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Humphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5725 CERTIFICATE OF DEATH

05857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u> d. STREET ADDRESS <u>8119 Flower Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thornton Macpherson Woodall</u>				4. DATE OF DEATH Month <u>5</u> / Day <u>18</u> / Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/8/91</u>			
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plastering Contractor - self</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>employed</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>Thomas J. Woodall</u>				14. MOTHER'S MAIDEN NAME <u>Louella Wedding</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W. 1</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Pf's Hosp. Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Atherosclerotic hypertensive heart disease 4 years</u> DUE TO (c) <u> </u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1959</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <u>1958</u> , 19 <u> </u> , to <u>5/18/59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>5/17/59</u> , 19 <u> </u> , and that death occurred at <u>7:35 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Bernard J. Walsh</u>				ADDRESS (Street, city or town, state) <u>900-17th St. S.W. 5/18/59</u>					
PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>				M.D. <u> </u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mausoleum</u>		22d. LOCATION (City, town, or county) <u>Prince Georges</u> (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St. NW</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 21 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Orlino L. Hanna</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. The first part of the document is a letter from the author to the editor, dated 10/10/1910. The letter is written in a very formal and polite style, typical of the early 20th century. It discusses the author's recent work and expresses a desire for publication. The letter is signed 'Yours faithfully, [Name]'.

2. The second part of the document is a letter from the editor to the author, dated 10/15/1910. The editor's letter is also formal and polite, acknowledging the author's work and discussing the publication process. It is signed 'Yours sincerely, [Name]'.

3. The third part of the document is a letter from the author to the editor, dated 10/20/1910. This letter is a response to the editor's letter and discusses the author's plans for the work. It is signed 'Yours faithfully, [Name]'.

4. The fourth part of the document is a letter from the editor to the author, dated 10/25/1910. The editor's letter discusses the final details of the publication and expresses hope for the work's success. It is signed 'Yours sincerely, [Name]'.

5. The fifth part of the document is a letter from the author to the editor, dated 10/30/1910. This is the final letter in the correspondence, where the author expresses gratitude and discusses the future of the work. It is signed 'Yours faithfully, [Name]'.

5865 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 1/2 hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALLIS Middle C Last WRIGHT				4. DATE OF DEATH Month MAY Day 13 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 30, 1898	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INTER'L REPRESENTATIVE ELEC. WORKERS				10b. KIND OF BUSINESS OR INDUSTRY INTER'L BPO. HOOD		11. BIRTHPLACE (State or foreign country) HULL, ENGLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FRANCIS WRIGHT				14. MOTHER'S MAIDEN NAME CHARLOTTE WALLIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1917-1919				16. SOCIAL SECURITY NO. INFORMANT Address MARTHA L. WRIGHT (Wife) AS ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 3 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 8-2 , 19 58 , to 5-13 , 19 59 , that I last saw the deceased alive on 5-13 , 19 59 , and that death occurred at 6:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Philip R. James M.D. Washington Clinic, D.C. PHYSICIAN'S NAME (Type) Philip R. James							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/16/59		22c. NAME OF CEMETERY OR CREMATORY Logan Cemetery		22d. LOCATION (City, town, or county) (State) Logan, Utah	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



In SENATE, January 11, 1900.
 REPORT
 OF THE
 COMMISSIONERS OF THE LAND OFFICE
 IN RESPONSE TO A RESOLUTION
 PASSED BY THE SENATE
 MAY 1, 1899.
 ALBANY:
 J. B. LEECH, PRINTERS.
 1900.